Supreme Court, U.S.
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No. 93-1349

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

DAVID L. RAMSEY, SECRETARY,
DEPARTMENT OF HEALTH AND HOSPITALS,
STATE OF LOUISIANA, *et al.*,
Petitioners,

v.

ABBEVILLE GENERAL HOSPITAL, *et al.*,
Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Boren Amendment to the Medicaid Act requires participating States to provide for payment for hospital services "through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards." 42 U.S.C. § 1396a(a)(13)(A). The questions presented are:

1. Whether the court of appeals, in reviewing whether the State complied with the procedural requirement that it "find[]" that its rates are reasonable and adequate, erred in conducting a *de novo* review of the quality of the State's "factfinding process," the "quantum of evidence" that supported the State's findings, and aspects of the State's rate-setting methodology.

2. Whether this Court should reconsider its decision in *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), that the Boren Amendment can be enforced by health care providers through an action under 42 U.S.C. § 1983.

PARTIES TO THE PROCEEDING

The petitioners are David L. Ramsey, Christopher Pilley, Carolyn Maggio, Howard Prejean, and Helene Robinson.

The respondents are:

Abbeville General Hospital
American Legion Hospital
Baton Rouge General Medical Center
Beauregard Memorial Hospital
Bogalusa Community Medical Center
Bunkie General Hospital
Dauterive Hospital
East Jefferson General Hospital
Glenwood Regional Medical Center
HCA North Monroe Hospital
Humana Hospital-Lake Charles
Humana Hospital-Marksville
Humana Hospital-Oakdale
Humana Hospital-Springhill
Humana Hospital-Ville Platte
Humana Hospital-Winn Parish
Jennings American Legion Hospital
Lady of the Sea General Hospital
Lafayette General Medical Center
Lake Charles Memorial Hospital
Lakeside Hospital
Lakewood Hospital
Lane Memorial Hospital
LaSalle General Hospital
Lincoln General Hospital
Madison Parish Hospital
Medical Center of Baton Rouge
Opelousas General Hospital
1Our Lady of Lourdes Hospital

Our Lady of the Lake Hospital
Pendleton Memorial Methodist Hospital
Rapides General Hospital
Richland Parish Hospital-Delhi
Richardson Medical Center a/k/a Richland Parish Hospital-Rayville
Riverside Medical Center
St. Ann General Hospital
St. Francis Medical Center
St. Patrick Hospital of Lake Charles
St. Tammany Parish Hospital
Schumpert Medical Center
Seventh Ward General Hospital
Slidell Memorial Hospital
Sterlington Hospital, Inc.
Thibodaux Hospital & Health Centers
Touro Infirmary
Tulane University Medical Center
Union General Hospital
West Calcasieu-Cameron Hospital
Women's & Children's Hospital

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ON PETITION FOR A WRIT OF CERTIORARI
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FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Petitioners David L. Ramsey, *et al.*, petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-28a) is reported at 3 F.3d 797. The opinion of the district court (App., *infra*, 29a-35a) is not reported.

JURISDICTION

The judgment of the court of appeals was entered on September 22, 1993. A petition for rehearing was denied, and the opinion was amended, on November 26, 1993. Pet. App. 36a-37a. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1988).

STATUTES AND REGULATIONS INVOLVED

Relevant provisions of 42 U.S.C. § 1396a(a)(13)(A), 42 U.S.C. § 1983, and 42 C.F.R. § 447 are reprinted at App., *infra*, 38a-41a.

STATEMENT

1. Medicaid is a cooperative federal-state program established by Congress "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980). If a State elects to participate in the program, it must comply with the requirements of the Medicaid Act and regulations promulgated by the Secretary of Health and Human Services. *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

Section 1902(a)(13) of the Medicaid Act sets out the requirements for reimbursement of health care providers. That section, as amended by the Boren Amendment, provides that a participating State's plan for medical assistance must

> provide . . . for payment . . . of the hospital services . . . through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

42 U.S.C. § 1396a(a)(13)(A) (1988) ("Boren Amendment").

The Secretary has promulgated regulations pursuant to the Boren Amendment that require participating States to provide "assurances" whenever a State Medicaid Plan is submitted to the Secretary for initial approval or amended. 42 C.F.R. § 447.253 (1992). In addition, the Secretary's regulations require participating States to make specified findings "[w]henever the Medicaid agency makes a change in its methods and standards, but not less often than annually." *Id.*

2. In 1983, soon after the enactment of the Boren Amendment, Louisiana adopted a new payment system for Medicaid inpatient hospital services. Louisiana's Department of Health and Hospitals ("LDHH") submitted its proposed plan to the federal Health Care Financing Administration ("HCFA"), with assurances that it had found that the reimbursement rates were adequate to meet the costs that must be incurred by efficiently and economically operated hospitals. The Secretary, acting through HCFA, approved the plan.

Under Louisiana's system, hospitals are reimbursed for 100 percent of all capital costs, educational expenses incurred by teaching hospitals, and malpractice expenses. The hospitals' remaining operating costs are reimbursed at a level determined by each hospital's "target rate." A hospital is reimbursed for 100 percent of its operating costs as long as the costs remain below the hospital's target rate; the hospital is not reimbursed for costs in excess of its target rate. The target rate thus provides hospitals with an incentive to control their operating costs.

Each hospital's initial target rate was based on its actual average operating cost per Medicaid discharge in 1980 or 1981, whichever was higher. In 1982, 1983, and 1984, Louisiana increased the target rates in accordance with a nationwide price index published by HCFA that tracks price changes for a "market basket" of goods and services purchased by hospitals. LDHH made an additional 1 percent upward adjustment in 1982 and 1983, and an additional 1/4 percent upward adjustment in 1984. During this period, Louisiana paid Medicaid providers the highest rates permitted under HCFA regulations.[1/]

In 1985 and 1986, LDHH amended its Medicaid plan to provide that there would be no increases in the target rates for cost periods beginning July 1, 1985, and ending June 30, 1987. The HCFA indices for 1985 and 1986 were, respectively, 0.21 percent and 1.15 percent. LDHH found it unnecessary to implement these small increases because the State's depressed economy restrained cost inflation, and

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[1/] The Boren Amendment places only a lower limit on Medicaid reimbursement rates; other provisions of the Medicaid Act and accompanying regulations place upper limits on Medicaid reimbursement rates. See 42 C.F.R. § 447.271 (upper limits based on customary charges); *id.* § 447.272 (upper limits based on Medicare principles).

because the target rates were so high in relation to actual hospital costs in Louisiana that they provided little incentive to control costs. The 1985 and 1986 amendments were submitted to HCFA with assurances that LDHH had found that the amended State Plan would result in rates that were adequate to meet costs that must be incurred by efficiently and economically operated hospitals. HCFA approved the amendments.

In 1988, the State amended its Medicaid plan to provide that target rates would not be increased for cost periods beginning July 1, 1988. LDHH's decision was based in large part on two factors. First, HCFA's national cost index was producing target rate increases that were too large for Louisiana, where economic conditions were depressed. Second, a freeze in the target rate was necessary to strengthen the State Plan's cost containment incentives, and to counteract increasing inefficiency in Louisiana's hospital industry. The amendment was submitted to HCFA with assurances that LDHH had found that the rates were reasonable and adequate under the Boren Amendment. The acting administrator of HCFA disapproved the amendment; an administrative appeal of that decision is pending.

The temporary freeze of target rates ended in 1990. Thereafter, target rates were increased by the amount of the HCFA index, or about 5 percent per year.

3. Respondents, 58 hospitals located in Louisiana, brought this action in 1991 alleging that petitioners had not complied with the requirements of the Boren Amendment. The district court granted petitioners' motion for summary judgment. The court, applying an arbitrary and capricious standard of review to "a state Medicaid agency's actions under the Boren Amendment," App., *infra*, 31a, held that the State had "adequately and properly set forth findings for the

decision it made in adopting changes in its plan during the years 1985, 1986, 1988, 1989, and 1990." *Id.* The court noted that "[t]he evidence submitted by [petitioners] is uncontroverted." *Id.*

4. The court of appeals reversed and ordered LDHH "to engage in a *bona fide* findings process." App., *infra*, 26a. The court first held that "[w]hether LDHH complied with the procedural requirements of the Boren Amendment is a question of law, subject to *de novo* review." *Id.* at 8a (citation omitted). Although the court acknowledged "a litany of cases for the indisputable proposition that a state agency's rate-setting action is entitled to considerable deference," *id.* at 7a, it concluded that "most" courts apply a *de novo* standard in reviewing compliance with the procedural requirements of the Boren amendment. The court acknowledged, however, that one court of appeals "review[s] . . . procedural compliance with the findings and assurances requirement under the arbitrary and capricious standard," *id.* at 8a n.7 (citing *Illinois Health Care Association* v. *Bradley*, 983 F.2d 1460, 1462-63 (1993)), and added that there is "bedlam" in the courts of appeals concerning the appropriate standard for reviewing substantive compliance with the findings requirement. *Id.* The court of appeals adopted a "two-step review process — *de novo* review of the state's fact-finding process and arbitrary and capricious review of the findings and rates." *Id.* at 11a.

The court acknowledged that "LDHH had made its findings and submitted assurances to HCFA for approval of its initial Medicaid plan in 1984 and all subsequent amendments to the plan's reimbursement rates." App., *infra*, 7a. The court nevertheless held that LDHH failed to make "findings in compliance with the Boren Amendment procedural requirements." *Id.* at 12a. The court observed that "[w]hat constitutes a Medicaid Act 'finding' has been defined in

different ways" by different courts. *Id.* at 14a. The court said that the finding issue turned on the following question:

> [W]hat is the minimum quantum of evidence that an agency must possess in its cognition to substantiate its assurances that the reimbursement rates in the Medicaid plan and any proposed amendments (1) reasonably and adequately meet the costs that must be incurred by efficiently and economically operated hospitals, (2) accommodate hospitals serving a disproportionate number of low income patients with special needs, and (3) adequately ensure that Medicaid recipients have reasonable access to inpatient hospital services of adequate quality.

Id. at 15a-16a. The court did not attempt to define the "minimum quantum of evidence that [a state] agency must possess," except to state that the agency "must show it conducted an objective analysis, evaluation, or some type of factfinding process." *Id.* at 16a.

The court then rejected petitioners' contention that Louisiana engaged in ongoing analyses of the adequacy of rates. The court did not question testimony by a LDHH official that she had examined "how costs had increased from the base period to the current audited period versus how the average target rate had increased in that same period of time" and determined that "the increases in the target rates were greater than the actual increases in costs." App., *infra*, 21a.[2/] But the court concluded that the State's "efforts . . . to satisfy the findings requirement" were inadequate, *id.*

[2/] In a footnote, the court listed 11 categories of information that state officials had considered before changing Medicaid reimbursement rates. App., *infra*, 19a-20a n.15.

at 21a n.15, and stated: (1) "[t]he 'costs' compared were the hospitals' total cost per discharge, without any separation of labor costs or other cost components"; (2) the State did not examine data from all hospitals, and did not employ "scientific methodology to determine that the hospitals reviewed were representative," and (3) the responsible state official "based the 'process' on what she thought was right based on her experience" and did not reduce her analysis to writing. *Id.* at 21a. The court stated that it was "not concerned with the adequacy of the [the State's] alleged 'findings,' but with LDHH's fact-gathering procedures." *Id.* at 20a n.15.

The court further concluded that "the method by which LDHH promulgated the initial target rates fails the Boren Amendment test." App., *infra*, 19a. The court stated that, because "each hospital's target rate initially included all allowable base year costs, without 'limit[] or cap[] in any respect to remove inefficient, uneconomic, or unnecessary costs,'" hospitals could be "deemed efficient and economic, even though they might have . . . some continued inefficiencies." *Id.* at 24a. The court stated that there was a "fallacy" in this methodology based on its conclusion that "[b]y enacting the Boren Amendment, Congress intended states to abandon . . . schemes that paid actual hospital costs." *Id.*

The court concluded that LDHH's "inability to articulate an orderly process of evaluation or to identify specific documents reviewed renders suspect its 'findings' and renders meritless its argument that it engaged in a *bona fide* findings process." App., *infra*, 27a. Accordingly, the court reversed the judgment of the district court and "order[ed] LDHH to engage in a *bona fide* findings process." *Id.* at 26a-27a.

REASONS FOR GRANTING THE PETITION

The court of appeals engaged in an intensive and wholly unwarranted review of the State's internal decisionmaking process under the guise of determining whether the State had complied with the straightforward procedural requirement that it "find" that its rates are reasonable and adequate. In *Wilder*, this Court observed that the Boren Amendment imposes only "bare" and "perfunctory" procedural requirements. 496 U.S. at 510, 513. It is undisputed that the responsible state officials at all required times "found" that the State's rates were reasonable and adequate, and submitted written assurances to that effect to the Secretary. The court of appeals' decision that this did not satisfy the procedural requirements of the Boren Amendment is contrary to the plain language of the statute and the statements of this Court in *Wilder*. In addition, the court of appeals disregarded the principle that courts should not engraft procedural requirements on agencies entrusted with substantive functions by Congress.

The court's additional conclusion that it was appropriate to determine under a *de novo* standard of review whether the State had engaged in an adequate "factfinding process" was a completely unwarranted expansion of the court's role in enforcing the Boren Amendment and is in apparent conflict with a decision of another court of appeals. The court's further conclusion that the State's basic rate-setting methodology is flawed went far beyond the proper boundaries of judicial review of procedural compliance with the "findings" requirement.

This case is one of many that has been brought under 42 U.S.C. § 1983 as a result of this Court's decision in *Wilder*. Judicial enforcement of the vague standards of the Boren Amendment has proved to be unworkable and disruptive.

Ironically, although the Boren Amendment was intended to reduce federal agency oversight of the ratesetting process, it is now providing for very extensive oversight by the federal courts. Moreover, *Wilder*'s conceptual underpinnings have been weakened by the Court's recent decision in *Suter* v. *Artist M*, 112 S. Ct. 1360 (1992). Accordingly, this case presents an appropriate opportunity for the Court to reconsider whether the Boren Amendment can be enforced by health care providers through an action under 42 U.S.C. § 1983.

I. THE COURT OF APPEALS' DECISION IS CONTRARY TO THE PLAIN LANGUAGE OF THE BOREN AMENDMENT AND CONFLICTS WITH DECISIONS OF THIS COURT AND OTHER COURTS OF APPEALS.

A. *The Court of Appeals' Decision Is Contrary to the Plain Language of the Statute and this Court's Decision in Wilder.*

The Boren Amendment requires that a State must "*find*[], and make assurances satisfactory to the Secretary," that its rates are reasonable and adequate. 42 U.S.C. § 1396a(a)(13)(A)(1988) (emphasis added). In *Wilder*, the Court distinguished between a "mere[] . . . procedural [right] that rates be accompanied by findings and assurances (however perfunctory) of reasonableness and adequacy" and "a substantive right to reasonable and adequate rates." 496 U.S. at 510. In drawing that distinction, the Court observed that the Amendment imposes only "bare procedural requirements." *Id.* at 513. See also *id.* at 527 (Rehnquist, C.J., dissenting) (Boren Amendment "establishes a procedure . . . . The first step requires the States to make certain findings. The second and only other step requires the States to make certain assurances to the Secretary and the Secretary — not the courts — to review those assurances").

The court of appeals reviewed only the State's compliance with the procedural requirements of the Amendment, which relate to the requirement that the State "find" that its rates are reasonable and adequate.[3/] But the court read the Boren Amendment as requiring far more than the "bare" requirement that "rates be accompanied by findings . . . (however perfunctory)." 496 U.S. at 510. According to the court of appeals, the word "finds" incorporates a requirement that the State engage in a "factfinding process" that generates a "minimum quantum of evidence . . . to substantiate [the State's] assurances." App., *infra*, 15a-16a. The court did not define what this required of a State, but held that Louisiana's approach of relying on the judgment of experienced state officials who analyzed hospital cost reports and other information was not sufficient.

The court's reading of the Boren Amendment is contrary to the ordinary meaning of the term "find." To "find" is "to arrive at (a conclusion)" or to "determine and declare (as a verdict in a judicial proceeding)." *Webster's Third New International Dictionary* 852 (1968). The court of appeals confused *whether* the State arrived at a finding that its rates were reasonable and adequate with *how* and *why* the State arrived at that conclusion. The latter issues simply are not relevant to the "bare procedural requirement" that the State make findings.[4/]

[3/] The court did not hold that the State failed to comply with the "assurances" requirement. To the contrary, it found that the State "submitted assurances to HCFA for approval of its initial Medicaid plan in 1984 and all subsequent amendments to the plan's reimbursement rates." App., *infra*, 7a.

[4/] The distinction between findings and the bases for findings is reflected in Section 8(b) of the Administrative Procedure Act, which applies to (continued...)

Under the guise of determining whether the State had complied with the procedural "finding" requirement, the court of appeals engaged in an extensive *de novo* review of various aspects of the State's ratemaking activities. It conducted the equivalent of review of agency action under the Administrative Procedure Act — *i.e.*, the court considered whether the State had compiled an administrative record that contained evidence sufficient to support the agency's rate decisions — without giving the State the benefit of a deferential standard of review.[5/] The court went so far as to conclude that there was a "fallacy in LDHH's rate-setting methodology," even though the rate-setting system had been approved by HCFA in 1983, seven years before the lawsuit was even filed.[6/] App., *infra*,

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[4/](...continued)
formal adjudications, and requires a statement of "findings and conclusions, *and* the reasons or basis therefor." 5 U.S.C. § 557(b)(3)(A) (emphasis added). Of course, the APA does not apply to this case, because the State of Louisiana is not a federal agency. See 5 U.S.C. § 551(1); *Mary Washington Hosp., Inc.* v. *Fisher*, 635 F. Supp. 891, 897 (E.D. Va. 1985). *Cf. Wilder*, 496 U.S. at 514 n.12 (discussing possibility that providers may be able to bring an action under the APA against the Secretary of Health and Human Services).

[5/] The court stated that LDHH (1) compared hospitals' total cost per Medicaid discharge, without comparing labor costs and other components of total cost; (2) failed to examine audited data from all Louisiana hospitals, or to use a "scientific methodology" to determine that the hospitals whose costs were reviewed were a representative sample; and (3) allowed state officials to act on the basis of their experience, and relied on information and analysis that was not reduced to writing. App., *infra*, 21a.

[6/] The supposed "fallacy in LDHH's rate-setting methodology" was that LDHH permitted rates to exceed an amount necessary to cover the costs that must be incurred by efficiently and economically operated hospitals. App., *infra*, 23a-24a. In fact, there was no "fallacy". The Boren
(continued...)

24a. In effect, the court converted a "bare" procedural requirement into a requirement entailing intrusive *de novo* judicial review of a wide range of rate-related matters. This erroneous expansion of the scope of review in a Boren Amendment case warrants review by this Court.

B. *The Decision Adds to the Confusion in the Courts of Appeals Over the Standard of Judicial Review in Boren Amendment Cases.*

Although this Court in *Wilder* declined to set forth the "the appropriate standard of review" in a Boren Amendment case, it observed that courts of appeals had generally "employ[ed] a deferential standard of review to evaluate whether the rates comply with the substantive requirements of the amendment." 496 U.S. at 520 n.18 (citing cases). As the court of appeals observed, App., *infra*, 9a & n.8, the courts of appeals are now in a state of "bedlam" concerning the appropriate standard for reviewing substantive compliance with the Boren Amendment.[7/] The court of appeals thought

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[6/](...continued)
Amendment prohibits States from paying *less* than the amount specified in the statute, but it does not prevent them from paying *more*. In this regard, the court's decision conflicts with the decision of the Seventh Circuit in *Wisconsin Hospital Ass'n* v. *Reivitz*, 733 F.2d 1226, 1233 (1984) which recognized that a State, in providing assurances under the Boren Amendment, "is merely . . . saying that, at the least, its plan conforms to federal requirements; the state does not certify that these rates are *only* or *barely* adequate".

[7/] Although some courts engage in "deferential[]" review, at least when the Secretary has accepted the State's assurances, see *Pinnacle Nursing Home* v. *Axelrod*, 928 F.2d 1306, 1313 (2d Cir. 1991), others do not. For example, the Third Circuit has held that it will apply the arbitrary and capricious standard to determine whether rates are "reasonable and (continued...)

it was escaping the bedlam and aligning itself with "most" other circuits by holding that the State's compliance "with the procedural requirements of the Boren Amendment is a question of law, subject to *de novo* review." App., *infra*, 8a. In fact, the procedural requirement is not a "question of law" — either the State made the requisite finding or it did not. Further, the court did not confine its *de novo* review to the "bare" procedural issue of whether a finding had been made, but examined on a *de novo* basis the adequacy of the State's "factfinding process" and even opined on whether there were "fallacies" in the underlying rate-setting methodology.

The application of a *de novo* standard of review was completely inconsistent with the court's expansive definition of the "procedural" finding requirement, a definition that included the quality of the State's "factfinding process," its "fact-gathering procedures" and the "quantum of evidence that [the] agency . . . possess[ed] in its cognition to substantiate its assurances." App., *infra*, 15a, 20a n.15. Other courts have made the same mistake, with the result that many States are now subject to an unwarranted, unintended and highly intrusive level of judicial review. See, *e.g.*, *Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 796 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990) (applying *de novo* review to determine if the State has "identif[ied] and determine[d]: 1) efficiently and economically operated

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2/(...continued)
adequate," while engaging in "plenary review" of "reasonable access" and "proportionate share" requirements. *West Virginia Univ. Hosps., Inc.* v. *Casey*, 885 F.2d 11, 24 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83 (1991). The Tenth Circuit's decision in *Amisub*, which was cited by the Court in *Wilder*, in fact engaged in *de novo* review of both procedural and substantive compliance with Boren Amendment. See *Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 795-96 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990).

hospitals; 2) the costs that must be incurred by such hospitals; and 3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals").

Moreover, the court recognized that its articulation of the standard of review was in apparent conflict with a decision of the Seventh Circuit applying an arbitrary and capricious standard of review. App., *infra*, 19a, citing *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460 (7th Cir. 1993), for the proposition that "procedural compliance with the findings and assurance requirement" is reviewed "under the arbitrary and capricious standard."

The court of appeals' decision warrants further review to clarify the standard of review that applies under the Boren Amendment, and to correct an erroneous application of a *de novo* standard of review that will disrupt the States' administration of the Medicaid program and destroy the flexibility that Congress intended to confer on the States by enacting the Boren Amendment.

C. *The Court of Appeals' Decision Is Contrary to the Principle That Courts May Not Impose Procedural Requirements on Agencies.*

This Court has recognized that judges should not "engraft[] their own notions of proper procedures upon agencies entrusted with substantive functions by Congress." *Vermont Yankee Nuclear Power Corp.* v. *Natural Resources Defense Council*, 435 U.S. 519, 541 (1978). In *Vermont Yankee*, the Court unanimously reversed a decision that "struck down [a] rule because of the perceived inadequacies of the procedures employed in the rulemaking proceedings." *Id.* at 541. The Court expressly stated that this principle applies in non-APA cases such as this one. *Id.* at 524. The

Court concluded that "[a]bsent constitutional constraints or extremely compelling circumstances the 'administrative agencies "should be free to fashion their own rules of procedure and to pursue methods of inquiry capable of permitting them to discharge their multitudinous duties."'" 435 U.S. at 543 (quoting *FCC* v. *Schreiber*, 381 U.S. 279, 290 (1965), quoting, in turn, *FCC* v. *Pottsville Broadcasting Co.*, 309 U.S. 134, 143 (1940)). See also *PBGC* v. *LTV Corp.*, 496 U.S. 633, 654 (1990) ("*Vermont Yankee* stands for the general proposition that courts are not free to impose upon agencies specific procedural requirements that have no basis in [a statute]").

That principle applies with particular force in this case. Medicaid is a "cooperative federal-state program," *Wilder*, 496 U.S. at 502, and federal courts should be especially reluctant to impose procedural requirements on state agencies. Furthermore, Congress enacted the Boren Amendment with the intention "that the primary responsibility for developing rates be transferred to the States," *id.* at 516, and that the States not be "overburden[ed] . . . with unnecessary and burdensome paperwork requirements," *id.* (quoting S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981). The federal courts certainly should not inject themselves into a role that Congress expressly transferred from the Secretary of HHS to the States.

The court's decision not only conflicts with *Vermont Yankee*, but also is in apparent conflict with the Ninth Circuit's decision in *Folden*, which recognized that "states are free to create their own methods of arriving at the required findings and . . . the finding process does not require any special studies or written findings." 981 F.2d at 1057. As a practical matter, the court of appeals' decision may require the State to provide a written statement of reasons for its action. This Court has held that even the APA does not require such

a statement of reasons for informal agency action. See *Camp* v. *Pitts*, 411 U.S. 138 (1973); *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402, 417-21 (1971).

II. THE COURT SHOULD RECONSIDER ITS DECISION IN *WILDER*.

This case presents an appropriate opportunity for the Court to reconsider its decision in *Wilder* that health care providers can enforce the provisions of the Boren Amendment through an action under 42 U.S.C. § 1983. *Wilder*, like a recent constitutional precedent overruled by this Court in *Payne* v. *Tennessee*, was "decided by the narrowest of margins, over [a] spirited dissent[] challenging the basic underpinnings of [the] decision[]." *Payne* v. *Tennessee*, 111 S. Ct. 2597, 2611 (1991). To be sure, the doctrine of *stare decisis* weighs against overruling a judicial decision, particularly in a statutory case. See, *e.g.*, *Patterson* v. *McLean Credit Union*, 491 U.S. 164, 172-73 (1989); *Square D Co.* v. *Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 409, 424 (1986). But the doctrine of *stare decisis* is not an "inexorable command." *Payne*, 111 S. Ct. at 2609; *Burnet* v. *Coronado Oil & Gas Co.*, 285 U.S. 393, 405-11 (Brandeis, J., dissenting). Other factors may outweigh the policy of *stare decisis*, as demonstrated by the numerous decisions of this Court overruling statutory precedents.[8/]

[8/] See, *e.g.*, *Monell* v. *Department of Social Servs.*, 436 U.S. 658 (1978) (overruling *Monroe* v. *Pape*, 365 U.S. 167 (1961)); *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36 (1977) (overruling *United States* v. *Arnold, Schwinn & Co.*, 388 U.S. 365 (1967)); *Lodge 76, International Ass'n of Machinists* v. *Wisconsin Employment Relations Comm'n*, 427 U.S. 132 (1976) (overruling *International Union, U.A.W.A.* v. *Wisconsin Employment Relations Bd.*, 336 U.S. 245 (1949)); *Braden* v. *30th Judicial Circuit Court*, 410 U.S. 484 (1973) (overruling *Ahrens* v. *Clark*, 335 U.S.

(continued...)

"In cases where statutory precedents have been overruled, the primary reason for the Court's shift in position has been the intervening development of the law." *Patterson*, 491 U.S. at 173. "Where such changes have removed or weakened the conceptual underpinnings from the prior decision, . . . the Court has not hesitated to overrule an earlier decision." *Id.* (citations omitted). That factor justifies reconsideration of *Wilder*. The Court's recent decision in *Suter* v. *Artist M*, 112 S. Ct. 1360 (1992) has removed the conceptual underpinnings from *Wilder*.

In *Suter*, the Court held that the "reasonable efforts" clause of the Adoption Assistance and Child Welfare Act of 1980, 94 Stat. 500, 42 U.S.C. § 671(a)(15), is not enforceable through an action under 42 U.S.C. § 1983. The Court's opinion in *Suter* did not adhere to the three-part analysis employed in *Wilder* (*i.e.*, whether the statutory provision was intended to benefit the plaintiff, whether it reflects a congressional preference rather than a binding obligation on the governmental unit, and whether the interest asserted by the plaintiff is so vague as to be beyond the competence of the judiciary to enforce). Instead, the Court, relying on *Pennhurst State School & Hospital* v. *Halderman*, 451 U.S. 1, 17 (1981), concluded that the statutory language at issue did not "unambiguously confer an enforceable right upon the Act's beneficiaries," because it is "at least as plausibly read to impose only a rather generalized duty on the State, to be enforced not by private individuals, but by the Secretary."

[8/](...continued)
188 (1948)); *Andrews* v. *Louisville & N.R.R. Co.*, 406 U.S. 320 (1972) (overruling *Moore* v. *Illinois Central R.R.*, 312 U.S. 630 (1941)); *Boys Markets, Inc.* v. *Retail Clerks Union, Local 770*, 398 U.S. 235 (1970) (overruling *Sinclair Refining Co.* v. *Atkinson*, 370 U.S. 195 (1962)); *Peyton* v. *Rowe*, 391 U.S. 54 (1968) (overruling *McNally* v. *Hill*, 293 U.S. 131 (1934)).

112 S. Ct. at 1370. The Court further departed from its analysis in *Wilder* by relying in part on the availability of other enforcement mechanisms, even though they were not sufficiently comprehensive to manifest Congress' intent to foreclose remedies under § 1983. Compare 496 U.S. at 520-23 with 112 S. Ct. at 1368-69. The Court's decision in *Suter* thus removes the conceptual underpinnings from *Wilder*. See *Arkansas Medical Soc'y, Inc.* v. *Reynolds*, 6 F.3d 519, 524 (8th Cir. 1993) (In *Suter*, "the Court did not proceed analytically as it had in recent precedents").

This Court has also overruled statutory precedents "because of inherent confusion created by an unworkable decision." *Patterson*, 491 U.S. at 173 (citations omitted). That has certainly been the case with the *Wilder* decision. Judicial experience since *Wilder* has shown that the extremely broad and vague terms of the Boren Amendment cannot be effectively enforced by the courts. The Boren Amendment refers to rates that are "reasonable" and "adequate" to cover the costs that "must be incurred by efficiently and economically operated facilities," but the Secretary has expressly declined to define these open-ended terms by regulation, and the courts have been unable to fill the "definitional abyss." See 48 Fed. Reg. 56047-56049; *Lett* v. *Magnant*, 965 F.2d 251, 253 (7th Cir. 1992).[9/] The courts

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[9/] See, *e.g.*, *Pinnacle Nursing Home* v. *Axelrod*, 928 F.2d 1307 (2d Cir. 1991); *Temple Univ.* v. *White*, 941 F.2d 201 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992); *West Virginia Univ. Hosp., Inc.* v. *Casey*, 885 F.2d 11, 24 (3d Cir. 1989); *Mississippi Hosp. Ass'n, Inc.* v. *Heckler*, 701 F.2d 511 (1983); *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460 (7th Cir. 1993); *Lett* v. *Magnant*, 965 F.2d 251, 253 (7th Cir. 1992); *Wisconsin Hosp. Ass'n* v. *Reivitz*, 733 F.2d 1226 (7th Cir. 1984); *Nebraska Health Care Ass'n* v. *Dunning*, 778 F 2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987); *Folden* v. *Washington State Dep't of Social & Health*

(continued...)

have adopted varying positions on the standard of judicial review (*e.g.*, compare the decision below with *Illinois Health Care*), on the scope of the procedural and substantive requirements of the Boren Amendment (*e.g.*, compare the decision below with *Folden*), on the requirements for making valid findings (*e.g.*, compare the 3-step procedure required by the Tenth Circuit in *Amisub*, which was explicitly not required by the Seventh Circuit in *Illinois Health Care*), and even on whether Boren Amendment "findings" need to be supported by written studies (*e.g.*, compare *Illinois Health Care* with *Folden*).

Moreover, judicial enforcement of the Boren Amendment has enmeshed lower federal courts in the minutiae of Medicaid rate-making activities, an area where they have little if any expertise. The Fifth Circuit's consideration in this case of such issues as whether the State considered an appropriately "scientific" sample of hospitals when analyzing hospital costs, or whether the State looked at labor costs as opposed to total costs, or whether "case mix changes" had been evaluated, is not atypical of judicial decisions under the Boren Amendment. App., *infra*, 21a-22a. Some district courts have seemingly examined virtually every detail of a State's ratemaking system, *e.g.*, *Multicare Medical Center* v. *Washington*, 768 F. Supp 1349 (D. Wash. 1991), and courts of appeals have at times behaved in a similar fashion. *E.g.*, *Illinois Health Care*, 983 F.2d at 1466 (reviewing the State's estimate of the number of minutes that it takes to feed a nursing home patient).

[2/](...continued)
Servs., 981 F.2d 1054 (9th Cir. 1992); *Amisub (PSL)* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990); *Colorado Health Care Ass'n* v. *Colorado Dep't of Social Servs.*, 842 F.2d 1158 (10th Cir. 1988); *Mary Washington Hosp., Inc.* v. *Fisher*, 635 F. Supp. 891 (E.D. Va. 1985); *Anco, Inc.* v. *State Health & Human Serv. Finance Comm'n*, 388 S.E.2d 780 (S.C. 1989).

The practical problems that Boren Amendment lawsuits present for States do not end with the ambiguity of the statute and the uncertainty in predicting what a reviewing court will do. The lawsuits tend to be expensive and complex, frequently result in burdensome discovery of the state officials' rate-making activities, often lead to the retention of outside consultants and experts, and otherwise complicate the State's administration of a highly complex and important welfare program. So far as the program recipients are concerned, a State's efforts to defend the lawsuits are of no benefit, nor is there an evident benefit for the recipients in judicial insistence on detailed and expensive "findings processes." The waste of resources is particularly evident in cases such as this one, where the issue being litigated is not whether the rates in fact are adequate to provide the level of compensation required by the statute but only whether the State has complied with a technical procedural requirement.

In sum, in light of the difficulties courts have experienced in applying the vague terms of the Boren Amendment, and the tension between *Wilder* and *Suter*, the Court should reconsider whether the Boren Amendment is enforceable through an action under 42 U.S.C. § 1983.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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February 24, 1994

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 92-3995.

ABBEVILLE GENERAL HOSPITAL,
et al., Plaintiffs-Appellants,

v.

David L. RAMSEY, Secretary, Department
of Heath and Hospitals, et al.,
Defendants-Appellees.

Appeal from the United States District Court for the Middle District of Louisiana.

Sept. 22, 1993.
As Remanded on Denial of Rehearing
Nov. 26, 1993

Before EMILIO M. GARZA and DeMOSS, Circuit Judges and Zagel[1], District Judge.

ZAGEL, District Judge.

A penny saved is a penny earned. That is the formula for federal Medicaid law — hospitals that save dollars by operating efficiently and economically earn state and federal dollars to cover all operating costs. The Medicaid Act,[2] specifically the Boren Amendment, provides that hospitals in participating states that operate "efficiently and economically" are entitled to reimbursement of costs which must be incurred. 42 U.S. § 1396a(a)(13)(A)(1991). Louisiana's Medicaid plan adopts the same formula since Louisiana elected to participate in the joint federal-state Medicaid program and receive matching federal funds. Louisiana's Department of Health and Hospitals ("LDHH"), under the direction of its secretary, administers its Medicaid plan.

As a participating state, Louisiana must comply with the Medicaid Act and implementing regulations promulgated by the Health Care Financing Administration (HCFA). *Amisub, (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 794 (10th Cir. 1989), *cert. denied*, 496 U.S. 935, 110 S.Ct. 3212, 110 L.Ed.2d 660 (1990). The federal structure gives each state Medicare agency a certain degree of flexibility in developing its Medicaid plan. Each plan, however, must provide for the reimbursement of inpatient hospital services:

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[1] District Judge of the Northern District of Illinois, sitting by designation.

[2] Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, is commonly referred to as the Medicaid Act.

> through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations and quality and safety standards.

42 U.S.C. § 1396a(a)(13)(A). In fact, the Supreme Court in *Wilder* v. *Virginia Hosp. Assoc.*, 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990), held that the leeway in adopting a method of computing rates does not relieve States of their obligation to pay reasonable rates. *Id.* at 2520. Once developed, each state must submit its plan to HCFA for approval. 42 U.S.C. § 1396. To secure HCFA approval, each state Medicare Agency must make findings and submit assurances to HCFA that: (1) the payment rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers"; (2) the methods and standards employed "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs"; and (3) the payment rates "are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality." 42 C.F.R. § 447.253(b)(1)(i), (ii)(A), (ii)(C) (1992). Such findings must be made and assurances filed with every amendment to established plans; findings must be made at least annually. 42 C.F.R. § 447.253(a), (b) (1992).

LDHH first developed its Medicaid plan for inpatient hospital services in 1983. Under the plan, LDHH reimburses hospitals 100 percent of all capital costs, educational expenses, and malpractice expenses. The remaining operating costs are

reimbursed either on a 100 percent basis or at a maximum level predetermined by each hospital's "target rate." LDHH set each hospital's initial "target rate" as the higher of its 1980 and 1981 average operating costs per Medicaid discharge. The plan allowed LDHH to increase these target rates in 1982, 1983, and 1984 in accordance with HCFA's inflation index published periodically. In 1985 and 1986, LDHH submitted proposed amendments to freeze the target rates for cost reporting periods beginning July 1, 1985 through June 30, 1987. HCFA approved this freeze. In 1987, LDHH resumed its plan and increased target rates up to 2.3% under the HCFA index. In 1988, LDHH again froze target rates until July 1, 1990, despite HCFA's disapproval of the proposed amendment.[3] Since then, target rates have increased annually by the amount of the applicable HCFA indices.

The dispute in Louisiana concerns whether LDHH made findings and submitted assurances as required by the Boren Amendment. The Hospitals[4] here complain that LDHH did not apply the "penny saved, penny earned" formula outlined in the Medicaid Act in deriving the reimbursement rates set under Louisiana's initial Medicaid plan and amendments for the years 1985, 1986, 1988, 1989 and 1990. The Hospitals

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[3] HCFA rejected LDHH's assurances and disapproved the 1988 amendment, stating that LDHH failed to "provide any information or data that demonstrates any relationship between [the 60 percent of the] facilities [being reimbursed their costs] and efficiency and economy . . . . [and] failed to substantiate its contention that its rates take into account economic conditions that will occur during the rate year." (Letter dated December 20, 1989 from Louis B. Hays, HCFA Acting Administrator, to Carolyn O. Maggio, LDHH Director.)

[4] Fifty-eight Louisiana hospitals ("Hospitals") joined to file this federal suit.

filed a § 1983 action against the Secretary of LDHH and other agency officials, claiming their actions deprived them of rights secured under the Boren Amendment. The Hospitals eventually moved for partial summary judgment declaring that LDHH failed, as a matter of law, to comply with the Boren Amendment when it established reimbursement rates and other payment schedules under Louisiana's Medicaid plan. In the motion, the Hospitals challenged LDHH's assurances submitted to HCFA, insisting that LDHH failed to make any "findings" that the rates set were reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals.

LDHH followed suit and filed a cross motion for partial summary judgment declaring that it complied with the findings process mandated in the Medicaid Act and its regulations. The district judge granted LDHH's motion for partial summary judgment, concomitantly denied the Hospitals' motion for summary judgment, dismissed the case in its entirety, and subsequently denied the Hospital's motion for a new trial, but amended his prior ruling.[5] The Hospitals now appeal. This Court has jurisdiction to hear their appeal under 28 U.S.C. § 1291.

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[5] In their motion for new trial, the Hospitals assigned error to the district court's dismissal of their claims challenging the substantive adequacy of the rates not raised in the cross motions for summary judgment. The district judge denied the motion without addressing the issue. Rather, in the October 26, 1992 ruling, Judge Polozola stated:

> The Court deletes from its first opinion the reference that the HCFA had approved the 1988 "freeze" amendment. This is a clerical error on the Court's part and has no bearing on the Court's final decision. As noted in the first opinion, the approval by the HCFA is not binding on the Court, but is evidence which may be considered by the Court.

On appeal, the Hospitals seek review of the district court's grant of summary judgment and other adverse rulings. The Hospitals maintain that the district court erred when it: (1) applied the highly deferential "arbitrary and capricious" standard of judicial review to the procedural issue of whether the LDHH complied with federal law; (2) determined that, as a matter of law, LDHH complied with the Boren Amendment and was entitled to summary judgment; and (3) dismissed the entire case, including the substantive issues on the reasonableness and adequacy of the reimbursement rates, after ruling only on the preliminary issue of procedural compliance with the Boren Amendment.

STANDARD OF REVIEW

We review a district court's grant of summary judgment *de novo*, employing the same standard as a district court would employ under Federal Rule of Civil Procedure 56(c). *Harbor Ins. Co.* v. *Urban Constr. Co.*, 990 F.2d 195, 199 (5th Cir. 1993). Summary judgment is proper only if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 250, 106 S.Ct. 2505, 2511, 91 L.Ed.2d 202 (1986). All reasonable inferences are drawn in favor of the nonmoving party. *Harbor*, 990 F.2d at 199. The parties here do not dispute the material facts. They argue whether the facts of record support a judgment as a matter of law that LDHH made appropriate findings and assurances in compliance with the Boren Amendment. LDHH says "yes"; the Hospitals say "no."

> Both parties concede that summary judgment was sought only on LDHH's procedural compliance with the Boren Amendment. LDHH argues that summary judgment, declaring LDHH had made valid findings,

automatically forecloses the Hospitals' challenge to the substantive adequacy of the rates set. *See infra* note 11, discussing propriety of district court's dismissal of case in its entirety. Still remaining unaddressed at trial are the Hospitals' claims related to outpatient services (subject of undecided motion to dismiss) and to the state plan's failure to provide adequate methods of accounting for changes in cases mix.

LDHH has made its findings and submitted assurances to HCFA for approval of its initial Medicaid plan in 1984 and all subsequent amendments to the plan's reimbursement rates. HCFA approved the plan and amendments to "freeze" reimbursement rates until 1988. LDHH contends that this federal agency action entitles Louisiana's plan to a presumption of regularity and warrants application of the arbitrary and capricious standard for reviewing the record to determine whether LDHH complied with federal law. LDHH cites a litany of cases for the indisputable proposition that a state agency's rate-setting action is entitled to considerable deference and is reviewable only under the arbitrary and capricious standard.[6] But this rule does not resolve the specific question presented here.

There is a fundamental difference under the Medicaid Act between an agency's discretion to set reimbursement rates and an agency's mandatory compliance with the findings and assurances requirements. It is LDHH's compliance or

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[6] *See, e.g., Let* v. *Magnant*, 965 F.2d 251, 257 (7th Cir. 1992) (plaintiff must establish "that the plan is either arbitrary and unreasonable or inadequate" and agency's actions are presumptively valid); *West Virginia Univer. Hosps., Inc.* v. *Casey*, 885 F.2d 11, 23-24 (3rd Cir. 1989) (court must apply "deferential standard of review in assessing compliance with the [Boren Amendment's] 'reasonable and adequate' requirement").

noncompliance with the findings requirement that is subject to cross motions for partial summary judgment. The findings requirement is both a procedural and a substantive requirement — LDHH must find that the rates are reasonable and adequate and the plan must adopt rates that are actually reasonable and adequate. *Wilder*, 496 U.S. at 512, 110 S.Ct. at 2519; *Illinois Heath Care Assoc.* v. *Bradley*, 983 F.2d 1460, 1463 (7th Cir. 1993) (distinguishing between the Boren Amendment's procedural component that the agency make findings and assurances and its substantive component that the plan implemented result in adequate payments). The Hospitals complained below of LDHH's noncompliance in practice with the findings requirement and the plan's noncompliance with the substantive findings requirement. 42 C.F.R. § 430.35(C) (1992) ("A question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement.")).

What standard does a federal court use to determine whether LDHH complied with the procedural requirements of federal law, i.e., whether LDHH, in fact, made the "findings" stipulated in the Boren Amendment? Whether LDHH complied with the procedural requirements of the Boren Amendment is a question of law, subject to *de novo* review. *Amisub*, 879 F.2d at 795. On this point most opinions are clear.[7] By conducting such a review of the agency's actions,

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[7] *But see Illinois Health Care*, 983 F.2d at 1462-63 (reviewing IDPA's procedural compliance with the findings and assurances requirement under the arbitrary and capricious standard). The Seventh Circuit states as its reason for deferential treatment of this issue that the Secretary's approval of the reimbursement plan renders the plan a "product of state and federal agency action." This reasoning, however, does not apply when the state makes findings. The Secretary does not participate in the agency's findings process. The Secretary's role is confined to

federal courts do not usurp the agency's permissible authority to balance political and financial interests underlying the Medicaid plan.

The opinions are not so clear on the proper standard for reviewing substantive compliance with the findings requirement.[8] The opinions generally recite the boiler plate language — *de novo* review of procedural and substantive compliance with federal law and arbitrary and capricious review of nonadjudicatory agency actions. Some opinions then proceed, we think, to conflate the issues reviewable for

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reviewing the reasonableness of the state's assurances. *Wilder*, 496 U.S. at 507-08, 110 S.Ct. at 2516-17. The Secretary neither reviews the methodology for reimbursement nor scrutinizes the underlying findings. *Id.* LDHH's findings, therefore, are not the product of state and federal agency action.

LDHH concedes in its brief that "conceivably a *de novo* standard might be appropriate" where no findings are made. Once *bona fide* findings are made, however, LDHH's expertise and the Secretary's approval warrant the same degree of deference to the rate-setting decision as accorded a federal agency. The court in *Illinois Health Care* recognized that determining the median cost of operating nursing homes that retain a basic level of care and pass inspection is a matter "for the state to solve by combining its economic expertise with its practical knowledge." 983 F.2d at 1465. But this expertise did not excuse the state agency's obligation to make findings which establish a nexus between the cost and the proposed reimbursement rates.

[8] In *Mississippi Hosp. Assoc., Inc.* v. *Heckler*, 701 F.2d 511 (5th Cir. 1983), we recognized this bedlam and "assum[ed] without deciding that by force of statutory or constitutional requirements, a district court is entitled to review the actions of a state agency administering federal Medicaid funding as it would review the actions of a federal agency." *Id.* at 516. We then proceeded, without further discussion, to determine whether both the plan's rates and the state Medicaid agency's findings were irrational and the product of arbitrary and capricious decision-making. *Id.* at 516-519.

substantive compliance with the Boren Amendment with issues reviewable as otherwise nonadjudicatory agency action.[9] Both involve a review of the underlying factual foundation and a substantive determination regarding the adequacy of the payment rates. Both implicate a balancing of policy and financial considerations. Both fall within the auspices of the state agency's exercise of discretion. Finally, both are reviewed to some degree by the Secretary prior to approving a plan or amendment. *See Illinois Health Care*, 983 F.2d at 1465 ("rate-setting and the identification of efficiently and economically operated facilities are all part of the same process") (quoting *Folden v. Washington State Dep't of Social*

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[9] The court in *Amisub* reviewed *de novo* whether the evidence was sufficient to support the "finding" and assurances that efficient and economical hospitals are reasonably and adequately compensated. 879 F.2d at 797-799. The opinion focused on (1) the expert testimony that no hospital, no matter how efficient, would be reimbursed for actual costs and (2) the program director's testimony that the assurances rested solely on the historical trend concept, i.e., the new system is adequate because it pays the same as the old system, which was adequate. The Tenth Circuit said that "[s]ince we find no evidence admitted at trial to support appellee's 'assurances' on appeal, and find overwhelming evidence to the contrary, we hold that the Colorado Medicaid Plan, effective July 1, 1988, is violative of the substantive provisions of federal Medicaid law." *Id.* at 799.

After this holding, the Tenth Circuit reviewed the record to determine whether the state agency's findings and assurances were reasonably related to a factual foundation or whether they were arbitrary and capricious. *Id.* at 799-801. Here, the court confined its review to whether the factors considered were relevant. The court then found that the "record is blatantly devoid of any effort ... to make the federally mandated findings" where the assurances are based solely on budgetary constraints. *Id.* at 800. The court ultimately remanded the case and ordered the state agency "to comply with the procedural and substantive requirements of the federal Medicaid Act and its implementing regulations, and to engage in a *bona fide* findings process before submitting any new plan and/or assurances to HCFA." *Id.* at 801.

& Health Servs., 744 F.Supp. 1507, 1533 (W.D. Wash. 1990)).

It is precisely the agency's exercise of discretion and the Secretary's approval that warrant application of the arbitrary and capricious standard of review. *Illinois Health Care*, 983 F.2d at 1462-63 (reimbursement plan, approved by Secretary and product of federal-state agency action, must be reviewed with the same deference accorded federal agency actions); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1313 (2d Cir. 1991). The reason for the policy of deferential review of a federal agency's interpretation of federal law is its "expertise and familiarity ... with subject matter of its mandate and the need for coherent and uniform construction of federal law nationwide." *Turner v. Perales*, 869 F.2d 140 (2d Cir. 1989). The joint federal-state Medicaid program and the rate-setting flexibility mandated by the Boren Amendment evoke the same policy. This two-step review process — *de novo* review of the state's factfinding process and arbitrary and capricious review of the findings and rates — provides the "minimum necessary to assure proper accountability." S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981), *reprinted in* 1981 U.S. Code Cong. & Admin. News 396, 744.[10] It also strikes a

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[10] In holding that the Boren Amendment creates a right enforceable under § 1983, the Supreme Court anticipated the debate over standards of review in this area. It stated, "That the Amendment gives the States substantial discretion in choosing among reasonable methods of calculating rates may affect the standard under which a court reviews whether the rates comply with the Amendment, but it does not render the Amendment unenforceable by a court." *Wilder*, 496 U.S. at 520, 110 S.Ct. at 2523. *Wilder* did not decide what standard a court should use to review a state agency's actions under the Boren Amendment. The Court, however, did acknowledge that the Secretary has "limited oversight" over the plans. Also, in holding that § 1983 allows for private enforcement of the Boren Amendment, the Court rejected the petitioners' argument that Congress gave the Secretary, not the federal court, power to ensure that the rates are

balance between Congress's view of the federal role under the Medicaid Act and general principles of federalism, which do not permit states to be final arbiters of their compliance with federal law. Accordingly, a presumption of regularity and deferential standard attaches to LDHH's exercise of discretion in setting reimbursement rates, but only after a reviewing court determines that LDHH made *bona fide* findings.

The first question then is whether LDHH made findings in compliance with the Boren Amendment procedural requirements. If yes, then and only then will we need to inquire into the substantive adequacy and reasonableness of these reimbursement rates using the arbitrary and capricious standard of review. *Wilder*, 496 U.S. at 520 n. 18, 110 S.Ct. at 2523 n. 18; *Nebraska Health Care Assoc.* v. *Dunning*, 778 F.2d 1291, 1294 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063, 107 S.Ct. 947, 93 L.Ed.2d 996 (1987). Even this standard and the presumption of validity do not shield LDHH from a "thorough, probing, in-depth review" of the Medicaid plan. *Illinois Health Care*, 983 F.2d at 1463 (quoting *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402, 415, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971) (reviewing under

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not based on false findings. *Id.* at 496 U.S. at 515, 110 S.Ct. at 2520. The Court's decision in *Wilder* suggests that Congress intended federal courts to give deference to a state's reimbursement rate determinations unless the assurances submitted are based on patently false findings. The Hospitals here contend any other result would render LDHH's duty to make findings a mere formality, and LDHH's duty to make appropriate findings under the Boren Amendment was not intended by Congress to be a mere formality. *Id.* at 515, 110 S.Ct. at 2520.

arbitrary and capricious standard the Secretary's approval of highway construction through park)).[11]

LDHH'S FINDINGS

The Hospitals contend the LDHH never engaged in a findings process to substantiate its compliance with the Boren Amendment and its implementing regulations. In their view, LDHH first erred by not adopting an objective profile of what constitutes an economically and efficiently operated hospital and, instead, arbitrarily defined an economic and efficient hospital as one whose costs do not exceed the assigned target rate. Second, LDHH improperly relied on "subjective, generalized and unsupported assumptions about the general state of the economy in Louisiana" in deviating from the state Medicaid plan and imposing target rate "freezes." Third, LDHH violated federal law because it implemented and continued the rate freezes in 1989 and 1990, after HCFA disapproved the TN 88-12 proposed freeze, and because LDHH did not submit assurances to HCFA for the years 1989 and 1990. LDHH responds that it made the appropriate findings and points to the affidavits of Carolyn O. Maggio (director of LDHH Bureau of Health Services Financing) and

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[11] The Hospitals also assign error to the district court's dismissal of the entire case, including the substantive issues on the reasonableness and adequacy of the reimbursement rates. This Court agrees that there was error in dismissing the substantive claims. The summary judgment motions pertained solely to the issue of procedural compliance with federal law. While procedural noncompliance renders futile any attempted substantive compliance, procedural compliance does not guarantee compliance with substantive federal law. *See Mississippi Hosp. Assoc., Inc.* v. *Heckler*, 701 F.2d 511 (5th Cir. 1983) (reviewing separately whether the state agency complied with the procedural requirements and whether the reimbursement rates were adequate in compliance with the substantive requirements of the Boren Amendment).

LDHH employee Helene Robinson (policy and program manager of Louisiana Medical Assistance Program).

Courts generally agree that a state can develop its own methodology for arriving at the required findings. *Amisub*, 879 F.2d at 797; *Illinois Health Care*, 983 F.2d at 1464. Regardless of the methodology, an agency still must make the required findings.[12] What constitutes a Medicaid Act "finding" has been defined in different ways in the last decades. Some opinions suggest that a finding simply consists

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[12] Federal regulations provide:

> (b) *Findings*. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:
>
> > (1) *Payment Rates*. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
> >
> > (ii) With respect to inpatient hospital services —
> >
> > > (A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;
> > >
> > > . . . .
> > >
> > > (C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 C.F.R. § 447.253(b) (1992).

of a "reasonably principled analysis." *Folden*, 744 F.Supp. at 1532. Others, ostensibly in the spirit of the Boren Amendment's flexible rate-setting scheme, pose that a finding is any showing of a "nexus" between reimbursement rates and efficiently and economically operated hospitals. *Pinnacle Nursing Home*, 928 F.2d at 1314. The most detailed definition of a finding appears in *Amisub*.

> [T]he plain language of federal Medicaid law mandates the State Medicaid Agency, *at a minimum*, to make "findings" which identify and determine 1) efficiently and economically operated hospitals; 2) the costs that must be incurred by such hospitals; and 3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals.

Amisub, 879 F.2d at 796 (emphasis in original).

Whether a court chooses to require a "reasonably principled analysis" or a "nexus" or a profile of efficiently and economically operated hospitals is not crucial to determining compliance with the findings requirement. All three of these cases adopt their own terminology to answer the same question. That is, what is the minimum quantum of evidence that an agency must possess in its cognition to substantiate its assurances that the reimbursement rates in the Medicaid plan and any proposed amendments (1) reasonably and adequately meet the costs that must be incurred by efficiently and

economically operated hospitals,[13] (2) accommodate hospitals serving a disproportionate number of low income patients with special needs, and (3) adequately ensure that Medicaid recipients have reasonable access to inpatient hospital services of adequate quality. 42 C.F.R. § 447.253(b)(1)(i), (ii)(A), (ii)(C) (1992).

The evidence clearly need not consist of the state agency's own comprehensive study of all state hospitals. In *Illinois Health Care*, the Seventh Circuit aptly observed that a sample of nursing homes as "paradigms of efficiency" may be impossible, waste money better spent on patients, and lead to more controversy. *Illinois Health Care*, 983 F.2d at 1464-65. On the other hand, the findings requirement is not a mere formality that can be satisfied simply by having a state officer think a bit about hospital costs and then copy out the statutory language on a piece of paper, put the heading "assurances" on that piece of paper, and send it to HCFA. *Wilder*, 496 U.S. 515, 110 S.Ct. at 2520; *Amisub*, 879 F.2d at 797; *see Pinnacle Nursing Home*, 928 F.2d at 1313-14 (procedural requirements are not "mere surplusage" but restrict the state's flexibility in formulating its reimbursement plan). The state agency must show it conducted an objective analysis, evaluation, or some type of factfinding process to determine the effects of the rates on the level of care Medicaid patients receive. *Nebraska Health Care*, 778 F.2d at 1294. As part of the factfinding process, the state agency must "judge the reasonableness of its rates against the objective benchmark of an 'efficiently and economically operated facility' providing care in compliance with federal and state standards while at

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[13] Part and parcel of this requirement is that a state find that lower rates are imposed on hospitals providing inappropriate levels of care as mandated in 42 C.F.R. § 447.252(a)(3)(ii). *Mississippi Hosp. Assoc., Inc. v. Heckler*, 701 F.2d 511, 521-22 (5th Cir. 1983).

the same time ensuring 'reasonable access' to eligible participants." *Wilder*, 496 U.S. at 519, 110 S.Ct. at 2522. This objective benchmark can be a "relative rather than an absolute concept." *Illinois Health Care*, 983 F.2d at 1467. It also can be implicit in a rate-setting methodology. *Id.*

LDHH admits, with some hesitation, that it conducted no studies and made no efforts to determine which state hospitals are efficiently and economically run. Instead, LDHH functioned under the premise that every hospital was economically and efficiently operated in 1981 and used the available cost reports for that base year to calculate the target rates for each hospital. Whether a particular hospital remains efficient and economical is gauged by whether the hospital stays within the designated target rate. Hospitals that exceed the designated target rate are deemed not efficient or economical and are not reimbursed actual costs. Rather, the hospitals receive the maximum payment determined by their respective target rates.[14]

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[14] Helene Robinson is the policy and program manager of the Louisiana Medical Assistance Program primarily responsible for administering the Medicaid plan and assuring compliance with federal law. Robinson's deposition on this point is worth an excerpt:

> Pizza [Counsel for the Hospitals]: Now what I'm trying to find out is, was any kind of study or analysis done to determine that hospitals that met or didn't meet their target rate were, in fact, either economic or not economic or efficient or not efficient?
>
> Robinson: Other than the deeming [of economic and efficient based on the target rate] —
>
> Pizza: Yes.
>
> Robinson: — as a result of the State plan?

Pizza: Right.

Robinson: I'm not aware of any.

Pizza: Now your answer is limited to '82, or is that for the whole period that you've been involved in the program?

Robinson: We do ongoing analyses of adequacies of the rates.

Pizza: I understand that, but I'm talking about the previous question. Has any study or analysis been done, to your knowledge, since you've been at the department concerning what you just answered?

. . . .

Robinson: Analyses that hospitals were efficient and economic if they were within their target rate?

Pizza: Right.

Robinson: We did those types of analyses. I mean, if they were within their target rate, they were deemed efficient and economic, even though they might have had some continued inefficiencies.

Pizza: So then some analyses have been done at some time to determine which hospitals are, in fact, economically and efficiently operated?

Robinson: They were deemed efficiently and economically operated if they were within —

Pizza: I'm still having a problem communicating then. I think it's clear so far that up to some period of time no studies were done to determine whether or not hospitals which met or didn't meet their target rate were, in fact, economically and efficiently operated?

Robinson: I don't know of any studies.

Pizza: Okay. What I'm trying to find out, is your answer limited to a particular year or does it cover the whole period of time you've

Clearly, the method by which LDHH promulgated the initial target rates fails the Boren Amendment test. LDHH did not make any finding that its plan complied with the three substantive requirements outlined in 42 C.F.R. § 447.253(b). Other than the cost reports, LDHH gathered no information and conducted no empirical analysis to ascertain whether the target rates "reasonably and adequately" compensated efficient and economical hospitals and hospitals servicing a disproportionate number of low income patients. "Federal law is not satisfied if a state merely makes conceptual policy decisions. A policy predicated upon provincialism and self-interest, not upon findings of reasonableness and adequacy, is unacceptable." *West Virginia Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 30 (3rd Cir. 1989).

LDHH insists that it engaged in "ongoing analyses of adequacies of the rates."[15] According to Robinson, in

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been working in the Medicare program?

Robinson: I guess it would cover about the whole time.

. . . .

Pizza: But would you say that if you don't know of any such studies, then, in fact, there probably were no studies?

Robinson: To any knowledge, there aren't any.

[15] LDHH argues that it considered numerous factors and information prior to imposing rate freezes:

> [1] Detailed operating and capital cost data for each hospital, including the extent to which individual hospitals recovered all or most of their operating costs[;]
>
> [2] [t]he long-term and continuing decline in hospital occupancy rates[;]

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[3] [h]ospital staffing levels[;]

[4] [n]umbers of licensed hospital beds[;]

[5] [t]he relatively few complaints regarding hospital quality of care, and information regarding hospital quality of care and information about certification of facilities[;]

[6] [i]nformation concerning continued expansion of hospital facilities[;]

[7] [i]nformation concerning entry and exit from the Medicaid program by inpatient hospitals[;]

[8] [t]he availability of an administrative process for reviewing and adjusting upwards the target rates of individual hospitals[;]

[9] [t]he State Plan's many generous features such as (i) 100 percent reimbursement of capital costs, malpractice and education expenses (ii) no cap on costs included in a facility's base year "target rate" calculation regardless of whether or not efficient; and (iii) generous per diem reimbursement of certain specialized care units, including neo-natal, burn, psychiatric and drug abuse units[;]

[10] [d]ata regarding employment, income and other economic trends nationally, in the Gulf Region, and in Louisiana, including information regarding the relatively depressed character of Louisiana's economy[; and]

[11] [t]he need for cost containment incentives.

(Appellee's Brief at 23-24 (record cites omitted).) LDHH cites only to Helene Robinson's affidavit as proof that it considered these factors. In determining whether LDHH complied with the procedural requirements of the Boren Amendment, this Court is not concerned with the adequacy of these alleged "findings" but with LDHH's fact-gathering procedures. Helene Robinson's affidavit indicates that she limited her review to the hospital's audited cost reports and data "gathered from other agencies and the media" on the general state of the economy in Louisiana (i.e.,

deciding to freeze the target rates, she "looked at how costs had increased from the base period to the current audited period versus how the average target rate had increased in that same period of time. And that the increases in the target rate were greater than the actual increases in costs." The "costs" compared were the hospitals' total cost per discharge, without any separation of labor costs or other cost components. Robinson retrieved this cost data from audited cost reports available for the latest time period. There were hospitals whose data was not considered. She did not employ a random statistical sampling or scientific methodology to determine that the hospitals reviewed were representative. Rather, Robinson admits in her deposition that she didn't do an actual analysis but based the "process" on what she thought was right based on her experience. Robinson further says that no analysis was done to determine if the uncounted hospitals skewed the results until 1987 or 1988.

Robinson says she reviewed other data available from the "Department of Labor and Statistics" and other publications reflecting general economic conditions. Robinson recalls in deposition she "had difficulty obtaining data on Louisiana-specific" information. She did manage to review "like weekly things in the newspaper . . . things in magazines and so on regarding, you know, unemployment, drops in personal income, and so on for the State." However, this analyses could not be reproduced because it was an "ongoing process" not reduced "necessarily [to] a written bound copy of something."

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recession and high unemployment rate) as compared to the nation. Robinson's deposition testimony clarifies exactly what efforts she made on behalf of LDHH to satisfy the findings requirement.

Furthermore, Robinson neither recommended to her staff nor initiated any efforts to obtain information regarding the economic conditions in the State as they affect hospitals, hospital labor costs, or any other costs that would be reflected in the hospital cost reports. Nor did Robinson recall having access to or using any studies or data base concerning such economic conditions and cost of care, or medical care, throughout the State. Finally, Robinson did not investigate the effects of case mix changes on Louisiana providers, such as increased outpatient services and longer hospital stays for inpatient services. What she says is this:

> Pizza: [W]as any study done by DHH during the period 1982 through 1989 to determine whether or not those factors influenced inflation for hospitals in Louisiana? [Those factors enumerated were the "increase in the hiring of Rns as opposed to LPNs, the increasing complexity of patient treatments, the trend of treating more outpatients [,] . . . that wage rates for hospital employees had climbed higher than for other kinds of employees, and finally that insurance costs had climbed at a higher rate for hospitals than it had for other industries nationwide."]
>
> Robinson: Studies were done in regard to hospital cost increases that would have reflected some of those factors.
>
> Pizza: I know, but was a study done, though, looking at those factors themselves and their effect on hospitals in Louisiana, germaine just to those factors?

Robinson: We look at the factors in the aggregate.

Pizza: So your answer then is no particular study was done to look at those individual factors; is that right?

Robinson: As I stated, we look at the factors and the increases in costs in the aggregate.

Pizza: Okay. Now when you say you looked at them in the aggregate, what did you do to look at them in the aggregate?

Robinson: We review cost data —

Pizza: Cost reports?

Robinson: — from the cost reports.

Pizza: So you examine cost reports to see how that data affected hospitals; is that right?

Robinson: We examine cost data to review — to determine the adequacy of the rates.

LDHH's purported "ongoing analysis" suffers from the same faulty logic as its initial rate-setting scheme. Findings were not made, instead assumptions were made. It is circular for LDHH to set target rates under the assumption that all hospitals are efficiently and economically operated and then identify efficiently and economically operated facilities as those whose costs fall below their own reimbursement rate. Under these circumstances, a hospital's ability to keep costs

below the target rate is not a reflection of its efficiency or economy of operations. Even Robinson admits this fallacy in LDHH's rate-setting methodology. She testified at her deposition that "if [the hospitals] were within their target rate, they were deemed efficient and economic, even though they might have had some continued inefficiencies." She also acknowledges in her affidavit that each hospital's target rate initially included all allowable base year costs, without "limit[] or cap[] in any respect to remove inefficient, uneconomic or unnecessary costs." By enacting the Boren Amendment, Congress intended states to abandon such "reasonable cost" schemes that paid actual hospital costs, despite obvious disparities in efficiencies and economies, in favor of reimbursement systems that encourage hospital efficiency and cost containment. H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981)[16]; *Temple University* v. *White*, 941 F.2d 201, 207 (3rd Cir. 1991); *West Virginia Univ. Hosp.*, 885 F.2d at 23.

LDHH has reduced its findings process to a simple exercise of compilation and assumption, completely ignoring the Congressional mandate that state agencies consider relevant factors such as efficiency, economy, quality of care, and reasonable access. LDHH emphasizes that it has received relatively few complaints regarding hospital quality of care.

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[16] The House of Representatives Report states in pertinent part:

> In eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that **promote the efficient and economical delivery of such services.**

H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981) (emphasis added).

This fact, however, says nothing about the reasonableness or adequacy of rates to meet the needs of efficiently and economically operated hospitals where rates initially set assume that every hospital is efficient and economic. At most, LDHH's "findings" process consisted of reviewing general information regarding the state of the economy and the available cost reports. LDHH can point to nothing in the federal Medicaid scheme that permits it to use the general state of the economy as the sole justification for setting rates.[17] Nor is there anything that condones a findings procedure that employs only historical cost data and projected inflation figures. To the contrary, courts have condemned similar schemes.

In *Amisub*, the state Medicaid agency presented as evidence of its "findings" process only a "consistency between the current expenditure for Medicaid provider reimbursement and the amount of money historically appropriated by the Colorado legislature, and HCFA's acceptance of the previous Colorado Medicaid Plan." *Amisub*, 879 F.2d at 796. The Tenth Circuit rejected this evidence as proof of "findings" for three reasons. First, the state agency's reliance on HCFA's approval of a previous plan belies the statutory requirement that agency's make at least annual findings. *Id.* at 797.

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[17] In *Illinois Health Care* v. *Bradley*, 983 F.2d 1460 (7th Cir. 1993), the Seventh Circuit affirmed the district court's declaratory judgment invalidating Illinois's Medicaid plan for failure to make proper findings. The rates allegedly were premised on time and motion studies conducted in the early 1980s in other states. *Id.* at 1466. Skeptical that the unproduced studies ever existed, the court found that the plan did not implicitly identify the economic and efficient nursing homes in Illinois and, thus, did not comply with the Boren Amendment's procedural requirements. *Id.* at 1467. The court also determined that a finding that a rate is adequate and reasonable merely because a number of nursing homes are profitable does not constitute a "finding" in compliance with the Amendment. *Id.*

Second, there is nothing in the Medicaid Act from which to infer that an agency may rely solely on the "historical trends concept" that the new plan is adequate because the monetary appropriations are identical to the old plan. *Id.* at 797, 799. Finally, a "record is blatantly devoid of any effort . . . to make the federally mandated findings" where the assurances are based solely on budgetary constraints. *Id.* at 800. The Tenth Circuit ultimately remanded the case and ordered the state agency "to comply with the procedural and substantive requirements of the federal Medicaid Act and its implementing regulations, and to engage in a *bona fide* findings process before submitting any new plan and/or assurances to HCFA." *Id.* at 801.[18] We too remand this case and order LDHH to engage in a *bona fide* findings process.

LDHH likens its case to that in *Mississippi Hosp. Assoc., Inc.* v. *Heckler*, 701 F.2d 511 (5th Cir. 1983), where we affirmed summary judgment declaring that Mississippi's Medicaid agency complied with the federal procedural requirements. *Mississippi Hosp.*, however, is inapposite for two reasons. First, in *Mississippi Hosp.*, we did not review whether the state agency engaged in a *bona fide* findings process. Rather, Mississippi's Medicaid agency was accused

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[18] In *Temple University* v. *White*, 941 F.2d 201 (3rd Cir. 1991), the court invalidated the Medicaid plan for failure to make "critical and required findings." The state agency's review of its rate scheme was confined to internally-generated reports identifying hospitals with reported costs above and below the group rates and to some revenue projections. *Id.* at 210. The agency also noted that it received no complaints from Medicaid recipients regarding their ability to obtain care. *Id.* Both the district and appellate courts concluded that the state agency "made no findings as to the reasonableness or adequacy of its rates to cover costs of an efficiently and economically operated hospital or to account for the impact on a hospital of its across-the-board budget neutrality adjustment and varying percentage add-ons for disproportionate-share hospitals .... [or to ensure] reasonable access to inpatient hospital care." *Id.*

of not complying with federal procedural requirements based on its failure to consult with the Medicaid Care Advisory Committee, its publication of an allegedly inadequate public notice, and its failure to submit proper assurances. *Id.* at 520. It is evident from our discussion that Mississippi engaged in a *bona fide* findings process and that we confined our review to the sufficiency of these findings under the arbitrary and capricious standard. *Id.* at 516-18. We have not reached this second stage of analysis in this case.

Second, we find no similarities between the findings processes adopted by LDHH and those adopted by Mississippi's agency. Mississippi based its rate ceiling on two-years and over 300 hours of "careful and objective studies of cost data filed by Mississippi hospitals . . .[,] methods used by other states and the federal government . . .[,] an incredible rage of cost incurred by hospitals," and statewide occupancy rates. *Id.* at 517, 520. Here, Robinson's review of cost reports was limited to comparing the available aggregate costs to the hospital's target rate to determine reimbursement.

This Court cannot endorse such a *pro forma* compliance with the findings requirement of the Boren Amendment. LDHH's inability to articulate an orderly process of evaluation or to identify specific documents reviewed renders suspect its "findings" and renders meritless its argument that it engaged in a *bona fide* findings process. Because we find that LDHH, as a matter law, failed to comply in practice with the Boren Amendment findings requirement, this Court REVERSES the district court's grant of LDHH's summary judgment motion and denial of the Hospitals' summary judgment motion. This

case is REMANDED for proceedings not inconsistent with this opinion.[19]

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[19] We express no view on whether the Hospitals' summary judgment motion may be defeated, in part or in whole, by various affirmative defenses which were neither ruled on in the district court nor argued in this Court.

APPENDIX B

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

ABBEVILLE GENERAL HOSPITAL,
ET AL

CIVIL ACTION
NUMBER 91-356-B

VERSUS

DAVID L. RAMSEY, SECRETARY
DEPARTMENT OF HEALTH AND HOSPITALS,
ET AL

RULING ON CROSS MOTIONS FOR SUMMARY JUDGMENT

This matter is before the Court on cross motions for summary judgment. The Court also questioned whether it has subject matter jurisdiction in this case.[1]

The plaintiffs are various hospitals in Louisiana. They have filed this suit pursuant to 42 U.S.C. § 1983 against the Secretary of the Department of Health and Hospitals and other employees in the agency. Plaintiffs contend that the manner and method used by the defendants in implementing the State Medicaid Plan deprive plaintiffs of their rights secured under the Boren Amendment to the Medicaid Act, 42 U.S.C. §

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[1] The Court has considered all of the briefs filed by the parties and the arguments made by counsel at oral argument whether discussed in this opinion or not.

1396(a)(13)(A), and the United States Constitution. Plaintiffs seek both injunctive and declaratory relief.

Defendants contend they have made adequate findings and assurances required under the Boren Amendment. Defendants further contend that the Medicaid reimbursement rates paid to the hospital were sufficient to meet the costs that are incurred by efficiently and economically operated medical providers.

Although the Court still questions its jurisdiction, the Court is bound by the latest expression from the United States Supreme Court in *Wilder v. Virginia Hospital Ass'n.*, 496 U.S. 498, 110 S.Ct. 2510 (1990) which held that the federal court has subject matter jurisdiction in this case.[2] Therefore, the Court finds that it has subject matter jurisdiction in this suit.

Summary judgment is proper when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. (Rule) 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986); *Anderson v. Liberty Lobby*, 477 U.S. 242, 106 S. Ct 2505, 91 L. Ed. 2d 202 (1986); *Fontenot v. UpJohn Co.*, 780 F.2d 1190 (5th Cir. 1986). Although the initial burden of proof is on the moving party, if the documentation supports the motion, the burden shifts to the non-moving party. *Landry v. Air Line Pilots Assoc. Int'l. AFL-CIO*, 901 F.2d 404 (5th Cir. 1999). To

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[2] The Supreme Court held: "[T]he Boren Amendment to the Medicaid Act creates a right, enforceable in a private cause of action pursuant to [42 U.S.C.] § 1983, to have the State adopt rates that it finds are reasonable and adequate rates to meet the cost of an efficient and economical health care provider." 119 S.Ct. at 2525.

oppose the granting of summary judgment, Rule 56(e) provides that "an adverse party may not rest upon the mere allegations or details of the adverse party's pleadings, . . . [instead, the defending party], by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." When all the evidence presented, by both parties, could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial. *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586, 106 S. Ct. 1348, 1356, 89 L. Ed. 2d 538 (1986).

The Medicaid program is a joint federal-state program which is designed to provide medical care and assistance to indigent persons. When a state elects to participate in the Medicaid program and reserve matching federal funds, the state must comply with the Medicaid statute and regulations which are promulgated by the Health Care Financing Administration (HCFA). The Boren Amendment, § 1396a(a)(13)(A), provides that each State plan must provide for the reimbursement of inpatient hospital services:

> "through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations and quality and safety standards."

Under the regulations set forth in 42 CFR § 447.253(b), the State Medicare Agency must make findings and submit assurance to HCFA that the rates are "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities." This submission must also be made to the HCFA when the plan is amended.

The plaintiffs in a Boren Amendment case have a heavy burden of proof. *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511 (5th Cir. 1983). A "presumption of validity attaches to agency action" in a Boren Amendment case. *Id.* at 517. The district court must use an "arbitrary and capricious" standard of review when examining a state Medicaid agency's actions under the Boren Amendment.

Applying the standard set forth above, the Court finds that the State of Louisiana has adequately and properly set forth findings for the decisions it made in adopting changes in its plan during the years 1985, 1986, 1988, 1989 and 1990. These findings are set forth in exhibits 5, 6, 7, 11, and 12. In addition, the defendants have set forth affidavits in support of their motion for summary judgment which explain their findings. The evidence submitted by the defendants is uncontroverted. It is also clear that the HCFA has accepted these findings. While the decision of the HCFA to accept the state's findings is not binding on the Court, it is evidence which may be considered by the Court in determining whether adequate findings were made by the State. Therefore, the Court finds that the defendants' motion for summary judgment should be granted and the plaintiffs' motion for summary judgment should be denied.

The parties have raised other issues in the motions for summary judgment. Because the Court has found that the defendants have made adequate findings, it is not necessary for the Court to rule on these additional issues.

Therefore, the Court finds that the Court has subject matter jurisdiction in this case. The Court further finds that defendants' motion for summary judgment should be granted and plaintiffs' motion for summary judgment should be denied.

Judgment shall be entered dismissing plaintiffs' case with prejudice.

Baton Rouge, Louisiana, September 9, 1992.

s/Frank J. Polozola
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

ABBEVILLE GENERAL HOSPITAL, ET AL

CIVIL ACTION
No. 91-356-B

versus

DAVID L. RAMSEY, SECRETARY DEPARTMENT OF HEALTH AND HOSPITALS, ET AL

JUDGMENT

For the written reasons assigned:

IT IS ORDERED AND ADJUDGED that judgment shall be entered in favor of the defendants and against the plaintiffs dismissing this suit with prejudice.

Baton Rouge, Louisiana, September 14, 1992.

s/Frank J. Polozola
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

ABBEVILLE GENERAL HOSPITAL,
ET AL

CIVIL ACTION
No. 91-356-B

versus

DAVID L. RAMSEY, SECRETARY
DEPARTMENT OF HEALTH AND
HOSPITALS, ET AL

RULING ON PLAINTIFFS' MOTION FOR NEW TRIAL

This matter is before the Court on plaintiffs' motion for a new trial. The Court deletes from its first opinion the reference that the HCFA had approved the 1988 "freeze" amendment. This was a clerical error on the Court's part and has no bearing on the Court's final decision. As noted in the first opinion, the approval by the HCFA is not binding on the Court, but is evidence which may be considered by the Court.

The evidence in this case is clear that defendants are entitled to summary judgment as a matter of law. For reasons set forth in the Court's opinion, the plaintiff's motion for a new trial is DENIED.

Judgment shall be entered accordingly.

Baton Rouge, Louisiana, October 26, 1992.

s/Frank J. Polozola
UNITED STATES DISTRICT JUDGE

APPENDIX C

U.S. COURT OF APPEALS
FILED
NOV 26 1993
CHARLES R. FULBRUGE III
CLERK

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

No. 92-3995

ABBEVILLE GENERAL HOSPITAL, ET AL.,

Plaintiffs-Appellants,

versus

DAVID L. RAMSEY, Secretary,
Department of Health and Hospitals, ET AL.,

Defendants-Appellees.

Appeal from the United States District Court
for the Middle District of Louisiana

ON PETITION FOR REHEARING

(Opinion September 22, 5th Cir., 1993, ____ 3d ___)

Before EMILIO M. GARZA, and DeMOSS, Circuit Judges.

and ZAGEL,* District Judge.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby DENIED. However, the panel opinion reported at 3 F.3d 797 is amended, by the addition of footnote 19 to the last paragraph of the opinion, as follows:

This Court cannot endorse such a *pro forma* compliance with the findings requirement of the Boren Amendment. LDHH's inability to articulate an orderly process of evaluation or to identify specific documents reviewed renders suspect its "findings" and renders meritless its argument that it engaged in a *bona fide* findings process. Because we find that LDHH, as a matter of law, failed to comply in practice with the Boren Amendment findings requirement, this Court REVERSES the district court's grant of LDHH's summary judgment motion and denial of the Hospitals' summary judgment motion. This case is REMANDED for proceedings not inconsistent with this opinion.[19]

---

* District Judge of the Northern District of Illinois, sitting by designation.

[19] We express no view on whether the Hospitals' summary judgment motion may be defeated, in part or in whole, by various affirmative defenses which were neither ruled on in the district court nor argued in this Court.

APPENDIX D

42 U.S.C. § 1396a(a)(13)(A)

Section 1396a(a)(13)(A) of Title 42, United States Code, provides, in part:

> a State plan for medical assistance must
>
> . . . .
>
> provide . . . for payment . . . of hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

* * * * *

42 U.S.C. § 1983

Section 1983 of Title 42, United States Code, provides, in part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of

any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

* * * * *

42 C.F.R. § 447

Section 447.253 of Title 42, Code of Federal Regulations, provides, in part:

(a) *State assurances.* In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (i) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) *Payment Rates.* (i) The Medicaid agency pays for inpatient services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services —

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

. . . .

(C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

* * * * *

Section 447.255 of Title 42, Code of Federal Regulations, provides:

The Medicaid agency must submit, with the assurances described in § 447.253(a), the following information:

(a) The amount of the estimated average proposed payment rate for each type of provider (hospital, ICF/MR, or nursing facility), and the amount by which that estimated average rate increased or decreased relative to the average payment rate in effect for each type of provider for the immediately preceding rate period;

(b) An estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on —

(1) The availability of services on a Statewide and geographic area basis;

(2) The type of care furnished;

(3) The extent of provider participation; and

(4) The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

* * * * *

Section 447.256(a)(2) of Title 42, Code of Federal Regulations, provides:

In the case of State plan and plan amendment changes in payment methods and standards, HCFA bases its approval on the acceptability of the Medicaid agency's assurances that the requirements of § 447.253 have been met, and the State's compliance with the other requirements of this subpart.

Supreme Court, U.S.
FILED

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No. 93-889

OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1993

DAVID L. RAMSEY, Secretary,
Department of Health and Hospitals,
State of Louisiana, *et al.*,

Petitioners,

vs.

ABBEVILLE GENERAL HOSPITAL, *et al.*,

Respondents.

Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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No. 93-889

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Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

STATEMENT

A. Statement of the Case

The Boren Amendment of the Medicaid Act[1] mandates that hospitals which operate efficiently and economically be reimbursed reasonably and adequately to meet the costs incurred. 42 U.S.C. § 1396a(a)(13)(A); 42 CFR § 447.253. Since Louisiana elected to participate in

[1] Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., is referred to as the "Medicaid Act."

the Medicaid program it must comply with the Medicaid Act and its implementing regulations. *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). The Louisiana Department of Health and Hospitals ("LDHH") is responsible for administering Louisiana's state plan.[2] The Hospitals[3] filed a § 1983 action against LDHH officials seeking relief from LDHH's method and manner of implementing the state plan which they believe ignored the requirements of federal law to the detriment of the Hospitals, the healthcare industry and the citizens of Louisiana.

Federal regulations, promulgated by the Health Care Financing Administration ("HCFA"), grant the states some flexibility in developing Medicaid plans, but federal laws and regulations set forth certain requirements which cannot be ignored. 42 U.S.C. § 1396a(a)(13)(A); 42 CFR § 447.253(a),(b)(1992); *Wilder*, 496 U.S. at 515, 110 S.Ct. at 2520. Each state's plan must establish a reimbursement policy for inpatient hospital services:

> through the use of rates . . . which the State **finds**, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to

---

[2] Louisiana Department of Health and Hospital officials named as defendants include David Ramsey, Secretary; Howard Prejean, Assistant Secretary; Christopher Pilley, Undersecretary; Carolyn Maggio, Medical Assistance Manager; and Helene Robinson, Medicaid Program Manager. They are sometimes collectively referred to as LDHH.

[3] Fifty nine hospitals ("Hospitals") originally joined to file this suit.

> provide care and services in conformity with applicable State and federal laws, regulations and quality and safety standards. (emphasis added).

42 U.S.C. § 1396a(a)(13)(A).

Each state Medicaid agency is entrusted by the federal government with the responsibility of making findings and then submitting assurances based on those findings to HCFA that its (1) rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers; (2) methods and standards take into account the situation of hospitals which serve a disproportionate number of low income patients of special needs; and (3) rates are adequate to assure that recipients have reasonable travel time, to inpatient hospital services of adequate quality. 42 CFR § 447.253(b)(1)(i), (ii)(A), (ii)(C)(1992). These regulations require that findings be made at least annually and that assurances, which guarantee the requirements of federal law are being met, are submitted with every amendment to the established plan. 42 CFR § 447.253(a),(b)(1992).

Louisiana promulgated its Medicaid plan for inpatient hospital services in 1983. The original rates paid were based on each hospital's 1980 or 1981 historical costs. LDHH set these "target rates" without regard to efficiency or economy. Indeed, the State has admitted that initially all hospitals were "deemed" economically and efficiently operated. Pet. App. A, p. 17(a).

In the first few years of operation, LDHH followed the state plan by increasing the rates using HCFA's inflation index. In 1985 and 1986 HCFA assented to the rate freeze proposed by LDHH relying on its assurance that requirements of federal laws and regulations were met.

However, in 1988 after implementing a 2.3% increase in 1987, LDHH again assured HCFA that a freeze of rates was appropriate. This time HCFA disapproved the amendment, unequivocally labelling LDHH's assurances as "unacceptable" and requesting additional information upon which LDHH based its proposed freeze amendment. Information satisfactory to HCFA has not yet been provided.[4] App. A, pp. 1a-5a.

---

[4] HCFA, through its Associate Regional Administrator James R. Merryman, originally informed LDHH of HCFA's intention to disapprove the rate freeze as it was unsubstantiated and failed to provide satisfactory assurances that it met the requirements of the Boren Amendment. Information was requested to substantiate the freeze. App. A, p. 1a. A second letter followed which stated: "The additional information you submitted on September 14, 1989 did not adequately address the concerns we expressed in our November 10, 1988 letter . . . you did not provide any information that demonstrates any relationship between these facilities and efficiency and economy." App. A, pp. 2a-3a. A third letter from HCFA's Acting Administrator, Louis B. Hays, finally disapproving the freeze amendment stated in part: "You furnished an assurance statement as required by 42 CFR 447.253(b)(1) that the proposed payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers. However, it is our decision that the assurance is unacceptable. Consequently, the proposed state plan amendment, transmittal number 88-12, is not in accordance with federal statutory requirements of Section 1902(a)(13)(A) of the Act. We believe that the State's assurance does not meet the fundamental requirement of Section 1902(a)(13)(A) of the Act. . . . [T]he State has failed to provide any information or data that demonstrates any relationship between these facilities [which were within the target rates] and efficiency and economy of operations." App. A, pp. 4a-5a.

Despite HCFA's disapproval of the 1988 proposed freeze, the State implemented the freeze and continued it until July 1, 1990. In 1989 LDHH did not file "assurances" with HCFA. Since the 1990-91 fiscal year, target rates have been increased by the applicable HCFA indices. These increases however did not include an adjustment for the "frozen" rates of prior years.

After initiating this suit, the Hospitals filed a motion for partial summary judgment declaring that LDHH failed, as a matter of law, to comply with the Boren Amendment in establishing and amending the Medicaid plan. Specifically, the Hospitals challenged the State's assurances submitted to HCFA, asserting that LDHH failed to make the requisite "findings" that the rates set were reasonable and adequate to meet the costs incurred by efficiently and economically operated hospitals.

LDHH filed a cross motion for summary judgment which the district judge granted. The Hospitals' summary judgment motion was denied and the entire case was dismissed. The Hospitals' motion for new trial was denied with the judge amending his ruling. The Hospitals appealed to the United States Court of Appeals for the Fifth Circuit which resulted in a reversal of the opinion below.

The Fifth Circuit, in a lengthy and well reasoned opinion, concluded that LDHH reduced its finding process:

> to a simple exercise of compilation and assumption, completely ignoring the Congressional mandate that state agencies consider relevant factors such as efficiency, economy, quality of care, and reasonable access. . . . At most, LDHH's "findings" process consisted of reviewing general information regarding the state of

> the economy and the available cost reports. LDHH can point to nothing in the federal Medicaid scheme that permits it to use the general state of the economy as the sole justification for setting rates. Nor is there anything that condones a findings procedure that employs only historical cost data and projected inflation figures. To the contrary, courts have condemned similar schemes. Pet. App. A, pp. 24a-25a.

The Fifth Circuit reversed the district court's grant of LDHH's summary judgment motion and denial of the Hospitals' summary judgment motion, holding that LDHH, as a matter of law, failed to comply in practice with the Boren Amendment's findings requirement.

B. Perceived Misstatements

Petitioners' application for writ of certiorari includes several perceived misstatements of fact and law. Petitioners state several times that LDHH's system of establishing and updating "target rates" acts as an incentive for cost control. Petitioners state that the freezes in rates implemented by the State were justified by a desire to strengthen the State's cost containment incentives. Pet. pp. 4-5. In fact, even the Medicaid program director admitted that in setting target rates there was never an attempt to establish a nexus between efficiency and economy of operations and the target rates. Pet. App. A, p. 17a. The Fifth Circuit also pointed out the failure of Louisiana's plan to include cost containment measures. Pet. App. A, pp. 23a-25a. In a system which does not establish a relationship between efficient and economic operations and the target rates there can be no incentive

to contain costs at all. In Louisiana, if a hospital's costs are below the target rate, the hospital would receive its actual costs rather than the higher target rate. So, to the extent that a facility may have operated inefficiently, it was rewarded to continue that inefficiency. Similarly, if a hospital operates very efficiently but its costs are above the arbitrary rate, it is penalized by receiving payment rates below costs.

In Petitioners' writ application, the statement of the case paints a distorted picture for this Court. Pet. pp. 2-8. For example, Petitioners state that LDHH found it unnecessary to implement certain increases in the target rate because of the State's depressed economy and because the target rates were so high in relation to actual hospital costs that there was little incentive to contain costs. Pet. p. 4. The record is devoid of credible evidence which would support any part of this statement. In fact, the only evidence which Petitioners could possibly rely on in support of this statement would be the affidavits submitted by various LDHH officials. As the Fifth Circuit noted in its opinion, these affidavits were largely discredited by subsequent deposition testimony of LDHH officials. Pet. App. A, pp. 17a-24a. The Medicaid program director neither recommended to her staff nor initiated any efforts to obtain information regarding economic conditions in the State of Louisiana as they may affect hospitals, hospital labor costs, or any other costs that would be reflected in the hospital costs reports. Pet. App. A, p. 22a. Nor did Ms. Robinson recall having access to or using any studies or data base concerning such economic conditions such as the actual cost of medical care in Louisiana. The Fifth Circuit noted in its opinion that Robinson did manage to

review "like weekly things in the newspaper . . . things in magazines and so on regarding, you know, unemployment, drops in personal income, and so on for the state." Pet. App. A, p. 21a. However, Robinson admitted having difficulty obtaining data on Louisiana specific information. *Id.* Further, LDHH cites nothing to support its novel concept that the target rates were so high in relation to actual hospital costs in Louisiana that they felt justified in freezing target rates.

Petitioners also attempt to justify the 1988 freeze which HCFA expressly disapproved. Pet. p. 5. Evidence in the record does not support Petitioners' assertion that HCFA's national cost index was producing target rate increases that were too high for Louisiana, particularly in light of the fact that the state official responsible made no studies or comparisons nor did she direct her staff to do so. Pet. App. A, pp. 21a-22a. As additional justification, Petitioners claim that the 1988 freeze was necessary to strengthen the state plan's cost containment incentives and counteract increasing inefficiency. This presumes that there were cost containment measures in Louisiana's plan, a fact which has never been established, and that there was any inefficiency in a particular Louisiana hospital or the hospital industry as a whole. There were admittedly no studies, no compilation of meaningful data and no analyses performed to determine the relationship between efficiency and economy and whether hospitals met their target rate. Pet. App. A, pp. 17a, n.14.

The Hospitals believe that the facts and LDHH's reaction to HCFA's disapproval of the 1988 freeze show LDHH's attitude toward federal oversight and direction. Unlike the picture painted by Petitioners, several letters

from different HCFA officials were sent to LDHH describing the inadequacy of Louisiana's system. App. A, pp. 1a-5a. One of HCFA's letters states:

> Under your definition, some hospitals are reimbursed their costs while others are not. The definition merely states that 60 percent of the facilities are reimbursed their costs (not that costs are reimbursed up to the sixtieth percentile). You did not provide any information that demonstrates any relationship between these facilities and the efficiency and economy.

In yet another letter, the HCFA administrator noted:

> [Y]ou furnished an assurance statement as required by 42 CFR 447.253(b)(1) . . . However, it is our decision that the assurance is unacceptable . . . We believe that the State's assurance does not meet the fundamental requirement of section 1902(a)(13)(A) of the Act . . . the State has failed to provide any information or data that demonstrates any relationship between these facilities and efficiency and economy of operations. We also believe that the State failed to substantiate its contention that its rates take into account economic conditions that will occur during the rate year. App. pp. 1a-5a.

Satisfactory information has not yet been provided to HCFA which would justify the state's actions.

Not only did LDHH implement the expressly disapproved 1988 freeze, but the State continued the illegal freeze through 1989 with no submission whatsoever to HCFA. This is an express and blatant violation of federal law. Petitioners attempt to justify their actions based on

the fact that they have appealed the 1988 decision. It is astounding that LDHH requested an appeal, has failed to provide satisfactory information to HCFA thus far, has implemented the expressly disapproved plan for several consecutive years and has managed to thwart federal oversight for six years. HCFA has taken no action on the appeal.

Another area of potential misunderstanding surrounds Petitioners' attempt to create a major split in the circuits regarding the standard of review. As is more fully discussed in Section I(B) hereof, there is no significant disagreement in the circuits regarding the standard of review applicable when determining whether a state made findings as required by federal law.

Finally, Petitioners state: "[i]t is undisputed that the responsible state officials at all required times 'found' that the State's rates were reasonable and adequate, and submitted written assurances to that effect to the Secretary." Pet. p. 9. Not only do the Hospitals dispute this statement but do so with support from the deposition testimony of the "responsible" state official, correspondence from HCFA, and the opinion of the Court of Appeals for the Fifth Circuit. Pet. App. A, pp. 17a-19a, 22a-23a; App. A, pp. 1a-5a, Pet. App. A. This Court and many lower courts have unequivocally and consistently reiterated the requirement that the findings process mandates the state to judge the reasonableness of its rates against an "objective benchmark" of an efficiently and economically operated facility. *Wilder*, 110 S.Ct. at 2525-26; *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1314-1315 (2nd Cir. 1991); *Temple Univ. v. White*, 941 F.2d 201, 210 (3rd Cir. 1991), *cert. den.*, 112 S.Ct. 873 (1992);

Abbeville Gen. Hosp. v. Ramsey, 3 F.3d 797, 804-807 (5th Cir. 1993); *Illinois Health Care Assoc. v. Bradley*, 983 F.2d 1460, 1465 (7th Cir. 1993); *Amisub (PSL), Inc. v. Colorado Dept. of Soc. Serv.*, 875 F.2d 789, 796 (10th Cir. 1989) *cert. den.* 110 S.Ct. 3212 (1990); *Kansas Health Care Assoc., Inc. v. Kansas Dept. of Soc. and Rehab. Serv.*, 958 F.2d 1018, 1023 (10th Cir. 1992); *Multicare Medical Center v. State of Washington*, 768 F.Supp. 1349, 1391 (W.D. Wash. 1991); *Missouri Health Care Assoc. v. Stangler*, 765 F.Supp. 1413, 1415 (W.D. Mo. 1991). What should be undisputed in this case is that LDHH has never judged the reasonableness of its rates against any sort of objective benchmark of an efficiently and economically operated facility.

SUMMARY OF ARGUMENT

I. The court of appeals' decision correctly determined that LDHH failed to comply with the findings requirement of the Boren Amendment with respect to the challenged agency actions. LDHH's essential position is that once a state agency merely claims to have made findings, its attestations of compliance with federal law should receive a rubber stamp of approval from the federal judiciary. Under this approach, it is difficult to perceive any form of judicial scrutiny of agency findings which LDHH would not consider to be unduly intrusive and unwarranted.

Neither the language of the Boren Amendment, nor any prior decision of this Court, nor any decision by any of the federal circuit courts of appeals supports the proposition that a state agency may comply with the findings

requirement by merely claiming that it has done so. Instead, the court of appeals' determination in this case that the state agency must possess a "minimum quantum of evidence . . . to substantiate its assurances that the reimbursement rates . . . reasonably and adequately meet the costs that must be incurred by efficiently and economically operated hospitals . . . ." *Abbeville*, 3 F.3d at 805, is consistent with both the wording of the statute and existing jurisprudence of this Court and of the federal circuit and district courts. While decisions of various federal circuit courts of appeals and district courts have used differing terminology to describe the showing which a state agency must make to establish that it has engaged in a valid findings process, all such decisions agree that there is a minimum standard which must be satisfied. Furthermore, no case has suggested that once the state agency merely declares that it has complied with federal law, further judicial scrutiny is foreclosed.

Accordingly, the court of appeals' determination that LDHH engaged in nothing more than "**pro forma** compliance with the findings requirement of the Boren Amendment" does not present an issue which warrants review by this Court. As detailed at length in the court of appeals' decision, LDHH offered nothing more than generalized, unsubstantiated and logically inconsistent assumptions as "findings," and can be said not to have truly engaged in a findings process as required by the statute. Contrary to LDHH's arguments, the court of appeals' conclusion that the state agency did not meet the minimum requirements of federal law hardly constitutes an invasion of the agencies rate-making discretion or involvement by the court in the intricacies of the rate-

making process. The court of appeals' decision recognizes that if LDHH would have simply followed federal law in the first instance by engaging in a good faith findings process, it would have been entitled to an appropriate amount of discretion in formulating Medicaid reimbursement rates.

II. This case does not present an appropriate vehicle for reconsideration of *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990); nor is reconsideration of this Court's decision in *Wilder* warranted by any subsequent decision of this Court or the federal circuit courts of appeals. *Wilder* recognized a private cause of action under the Boren Amendment and in favor of health care providers to enforce the substantive requirement that Medicaid reimbursement rates be reasonable and adequate to meet the costs required for operation of efficient and economic hospitals. This case, however, is presently before the Court in connection with the Hospitals' effort to enforce compliance by the state agency with the procedural requirements of the Boren Amendment. Both the majority and the dissenting opinions in *Wilder* recognized that a private cause of action to enforce procedural compliance under the Boren Amendment exists, and LDHH raises no basis for reconsideration of that determination. Furthermore, *Wilder* is distinguishable from this Court's subsequent decision in *Suter v. Artist M.*, 112 S.Ct. 1360 (1992), and LDHH's contention that *Wilder* should be overruled because federal courts are not capable of effectively reviewing state agency compliance with the Boren Amendment is disproved by the consistency and significance of the Boren Amendment cases decided by the federal courts subsequent to *Wilder*.

REASONS FOR DENYING THE WRIT

I. THE COURT OF APPEALS' DECISION IS CONSISTENT WITH THE PLAIN LANGUAGE OF THE BOREN AMENDMENT AND DOES NOT CONFLICT WITH DECISIONS OF THIS COURT AND OTHER COURTS OF APPEALS.

A. The Court of Appeals' Decision Is Consistent With the Plain Language of the Statute and this Court's Decision in *Wilder*.

The plain language of the Boren Amendment requires that a state must "**find**[], and make assurances satisfactory to the Secretary" that its rates are reasonable and adequate. Rather than being "contrary to the plain language of the statute," as LDHH argues, the court of appeals' decision upholds the statute by enforcing the requirement of findings. LDHH, on the other hand, invites this Court to treat the statutory requirement of findings as a meaningless formality, which any state can satisfy merely by making a self-serving proclamation that it has made findings. No decision of this Court, or of any circuit court of appeals, supports LDHH's position, which calls not for a plain reading of the statute, but for outright disregard of an express statutory requirement, i.e., the requirement of findings.

LDHH repeatedly culls from this Court's decision in *Wilder* a reference to the Boren Amendment's "bare procedural requirements," 496 U.S. at 513, 110 S.Ct. at 2519, thereby implying that *Wilder* supports its position that

the findings requirement may be satisfied through nothing more than departmental attestations of compliance. When read in proper context, however, the *Wilder* decision's use of the phrase "bare procedural requirements" hardly supports LDHH's position. In considering the issue of whether the statute provides health care providers with a right to enforce the substantive requirement of reasonable and adequate rates, the majority opinion referenced the dissenting opinion's view that "the only right enforceable under [Section] 1983 is the right to compel compliance with these **bare procedural requirements.**" *Id.* (emphasis added). While this comparative reference is interesting because it demonstrates that even the dissenters in *Wilder* recognized a private cause of action for enforcement of procedural rights under the statute, it was hardly offered as a comment on the importance of findings or the standard of judicial review applicable to the findings process, issues not then before the Court.

However, were one to look to the language of the *Wilder* decision for guidance as to those issues, it is apparent that this Court hardly treated the statutory requirement of findings as inconsequential. In fact, the *Wilder* decision rejected the position of the United States, as amicus curiae, that "the statute requires only that a State provide assurances . . . and that assurances do not give rise to enforceable rights," for the reason that:

> This interpretation ignores the language of the statute that requires a State to **find** that its rates are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" and to assure that

> eligible individuals have "reasonable access" to services. . . . The requirement that a State make such a finding is a necessary pre-requisite to the subsequent requirement that the State provide "assurances" to the Secretary. . . . Moreover, the Secretary's interpretation of his role under the statute – that he will review the reasonableness of the assurances presented by a State rather than the findings themselves – is based entirely on his understanding that a State has the responsibility to **find** that its rates are adequate before making assurances to the Secretary.
>
> *Id.* at 513, n. 11 (emphasis by the Court).

Given that this Court's decision in *Wilder* describes the findings process as a "necessary prerequisite" to any reimbursement plan, and as the "responsibility" of the state, there is no support for LDHH's contention that *Wilder* is inconsistent with the court of appeals' decision in this case. Instead, the court of appeals' determination that the findings requirement has true meaning and requires a "factfinding process" that generates a "minimum quantum of evidence" is legally and logically consistent with *Wilder*'s determination that the statutory requirement of findings evidences Congressional intent to provide a cause of action in favor of health care providers, not only to enforce procedural compliance with the Boren Amendment, but also to enforce the substantive requirement of states to provide reasonable and adequate rates.

After all, this Court reasoned in *Wilder* that "[a]ny argument that the requirements of findings and assurances are procedural requirements only and do not

require the State to adopt rates that are actually reasonable and adequate is nothing more than an argument that the State's findings and assurances need not be correct," and rejected that argument because "it would render the statutory requirements of findings and assurances, and thus the entire reimbursement provision, essentially meaningless." *Id.* at 513, 514. Similarly, if the court of appeals' decision in this case that the findings requirement requires a "factfinding process" and a "minimum quantum of evidence" is wrong, as LDHH argues, then the findings requirement would be rendered meaningless because all that would be needed for compliance is the State's mere attestation that it has made findings. *Wilder* does not remotely sanction such an approach.

Citing *Webster's Third New International Dictionary*, LDHH defines the term "find" as "to arrive at (a conclusion)" or to "determine and declare (as a verdict in a judicial proceeding)." Relying on these definitions, LDHH appears to contend that a state may satisfy the findings requirement by mere declaration; once the declaration is made, it is not subject to judicial scrutiny. Yet even LDHH would acknowledge the right of health care providers to bring suit if the state outright refused to make findings. What then of a case where the state **claims** to have made findings, but cannot substantiate them in any meaningful way (i.e., this case)?

LDHH seemingly contends that the **claim of compliance** blocks judicial scrutiny, but the court of appeals

correctly declined to adopt that view in this case.[5] For if the claim of compliance alone blocks judicial scrutiny, then in reality there is no findings requirement, and the "plain language" of the statute, to use LDHH's phrase, is eviscerated. Rather, as the court of appeals held in this case, the law does not permit "such a **pro forma** compliance with the findings requirement of the Boren Amendment."

LDHH also incorrectly characterizes the court of appeals' decision as "entailing intrusive **de novo** review of a wide range of rate-related matters." There is a distinct difference between the court of appeals telling LDHH that it did not do **nearly enough** by way of findings, as opposed to dictating to LDHH the manner in which findings should be made and rates set. The court

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[5] If it is not LDHH's position that the findings requirement may be satisfied by the state's mere claims of compliance, then it is difficult to ascertain how, as a practical matter, courts would measure compliance under the "arbitrary and capricious" standard advocated by LDHH. LDHH repeatedly criticizes the court of appeals' determination that a "minimum quantum of evidence" is necessary to support findings, yet if there is no minimum threshold for sufficiency of evidence of compliance, how can the standard of review be anything but **pro forma**, or totally dependent upon the state's mere claim of compliance? If the test for compliance is not to be governed solely by the state's claim of compliance, then what sort of review would LDHH permit? Probably none, for it is difficult to imagine any judicial determination that a promulgated finding is inadequate which LDHH would not characterize as an unwarranted invasion of agency discretion. The true bottom line of LDHH's position is that once the State claims that it has made findings, **there is no room for judicial review of any kind**.

of appeals engaged in the former process, but not the latter.

LDHH has been instructed by the court of appeals that it must do something more than make reference to generalities gleaned from newspapers about the state economy as a basis for freezing rates, that it must do something more than arbitrarily presuming that hospitals are or are not "efficient and economic" based upon a target rate that concededly has no connection to efficiency and economy of operations, and that it must do something more than engage in sweeping assumptions about hospital costs based upon incomplete and generalized cost data. The court of appeals' decision, however, does not purport to dictate or specify the additional steps LDHH must take in making findings, thus allowing for flexibility and an appropriate degree of deference for the rate making process.

Instead, the Fifth Circuit's decision simply and unambiguously instructs LDHH to take the statutory findings requirement seriously, and to stop belittling that requirement by claiming to have engaged in a meaningful fact-finding process when in fact it obviously has not. Faced with the court of appeals' instruction that it comply with federal law, LDHH now asks this Court to take away a reviewing court's authority to so instruct good faith agency compliance with the Boren Amendment. If in fact the authority of federal courts to engage in such review were to be taken away, the findings requirement would become meaningless indeed.

B. There Is No "Confusion" in the Courts of Appeals Over the Findings Requirement.

LDHH seizes upon the court of appeals' reference in a footnote to "bedlam" among the circuit courts on the issue of standard of review applicable to **substantive compliance** with the Boren Amendment as a basis for arguing that there is "confusion" among the courts of appeals on the standard of review applicable to **procedural compliance** with the statute. In reality, there is neither "bedlam" nor "confusion" among the circuits as to the standard of review applicable to procedural compliance – the issue presented by this case – but consistency. As the court of appeals observed, "[w]hether LDHH complied with the procedural requirements of the Boren Amendment is a question of law, subject to **de novo** review. . . . On this point most opinions are clear." *Abbeville*, 3 F.3d at 802. **See, e.g.**, *Amisub (PSL), Inc. v. Colorado Department of Social Services*, 879 F.2d 789, 795 (10th Cir. 1989), **cert. denied**, 496 U.S. 935 (1990); *Mississippi Hospital Association, Inc. v. Heckler*, 701 F.2d 511, 516 (5th Cir. 1983); *Multicare Medical Center v. Washington*, 768 F. Supp. 1349, 1389 (W.D. Wash. 1991); *Folden v. Washington State Dep't of Social & Health Services*, 744 F. Supp. 1507, 1532 (W.D. Wash. 1990), **aff'd**, 981 F.2d 1054 (9th Cir. 1992).

The principle supporting **de novo** review of a state's procedural compliance with the Boren Amendment is as simple as it is compelling: when a state agency makes a proclamation that it has complied with federal law, it is not engaging in a specialized or regulatory function of the kind traditionally afforded deference by federal

courts. Instead, the agency is reporting to the federal government that it believes it has complied with the mandates of federal law. The process cannot stop there. There is no rational basis for providing deference to a state agency's attestation that it has complied with federal law. *Erie County Geriatric Center v. Sullivan*, 952 F.2d 71, 79 (3rd Cir. 1991). **De novo** review by federal courts is necessary to insure uniformity in the interpretation of federal law, and to prevent the delegation of that inherent power of the federal judiciary to fifty different state agencies.

Indeed, in exercising **de novo** review of Boren Amendment procedural requirements, the federal circuit courts have arrived at remarkably uniform conclusions on the issue of **the minimum steps** that a state agency must take with respect to the findings requirement of the Boren Amendment. The language used by various courts to describe what constitutes sufficient findings varies. In *Folden*, 744 F.Supp. at 1532, the court required a "reasonably principled analysis." In *Pinnacle*, 928 F.2d at 1314, the court required a "nexus" between reimbursement rates and efficiently and economically operated hospitals. In *Amisub*, 879 F.2d at 796, the court required findings which identify and determine efficiently and economically operated hospitals, the costs that must be incurred by such hospitals and payment rates which are reasonable and adequate to meet such costs.

As the Fifth Circuit recognized in this case, however, the differing terminology used in these decisions is directed toward solving the same inquiry: "what is the minimum quantum of evidence that an agency must possess in its cognition to substantiate its assurances that the

reimbursement rates . . . reasonably and adequately meet the costs that must be incurred by efficiently and economically operated hospitals. . . . " *Abbeville*, 3 F.3d at 805. Essentially the same inquiry was made in *Illinois Health Care Ass'n v. Bradley*, 983 F.2d at 1462-63, where the court of appeals stated that it was reviewing the state plan "with the deference accorded federal agency actions" because the challenged plan provisions were the product of "state and federal agency action," but nevertheless found that the state had failed to "make findings that establish a nexus between the costs of operating [efficient and economic] facilities and its reimbursement rates." *Id.* at 1467.

The approaches taken in these various federal court of appeals decisions reveal that there is no true conflict among the circuits on the issue of sufficiency of findings, as all pertinent cases take the position that there must be, in the Fifth Circuit's words, a "minimum quantum of evidence" to substantiate that an agency's assurances that its plan and any proposed amendments will reasonably and adequately meet the costs that must be incurred by efficiently and economically operated hospitals. While different cases use different terminology to ask the question of whether that minimum quantum of evidence is present, it is most significant that **all of the cases, whether describing their review process as "de novo" or otherwise, do in fact ask the question.** LDHH's position is that the question should not be asked at all, and that judicial review should be foreclosed once the state agency says that it has made findings. Not a single case, even among those decisions which expound at length upon the importance of agency discretion, supports that position.

Ironically, LDHH complains that the court of appeals does not provide a specific definition of the "minimum quantum of evidence" necessary to constitute adequate findings. A rigid definition or formula for what constitutes a finding, however, would defeat the very flexibility in plan formulation for which LDHH argues in other contexts. The court of appeals' decision strikes an appropriate balance by not attempting to limit what a state agency may do when engaging in the findings process, while at the same time making clear what it may not do, i.e., it may not treat that process as a meaningless formality by claiming to make findings that have no reasonable basis.

C. The Court of Appeals' Decision is Not Contrary to the Principle That Courts May Not Impose Procedural Requirements On Agencies.

In responding to LDHH's contention that the court of appeals has unduly imposed its own requirements upon the state's system of Medicaid reimbursement, it is important to clarify what the court of appeals decision does **not** do. The court of appeals' decision does not dive into the complexities of Medicaid reimbursement methodology or substitute its judgment as to such methodology for that of the state agency. The court of appeals' decision does not attempt to limit or restrict the manner in which the state agency may make findings or seek to establish a nexus between its chosen method of reimbursement and the requirements of the statute. The court of appeals' decision does not attempt to lessen the traditional deference afforded to state agency action once the requirements of federal law have been met. And the court

of appeals' decision does not impose any procedural requirement upon LDHH other than the basic and unavoidable requirement that the agency comply with the mandates of the Boren Amendment.

On the other hand, what the court of appeals' decision **does do** is to review the superficial, arbitrary and illogical explanations offered by LDHH as "findings," and reject those explanations as insufficient to meet the requirements of federal law. This case is not an example of judges seeking to "engraft[] their own notions of proper procedures upon agencies entrusted with substantive functions by Congress," as LDHH suggests (quoting *Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council*, 435 U.S. 519, 525 (1978)), but is instead an example of a federal court decision which appropriately constrains a state agency from ignoring federal law. It is consistent and comports with the House Report which essentially provides that states should be given latitude regarding the development and implementation of reimbursement methodologies that **promote the efficient and economical delivery of such services**. H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981). (emphasis added)

II. RECONSIDERATION OF THIS COURT'S DECISION IN *WILDER* IS NOT WARRANTED.

Wilder held that health care providers have a private cause of action to enforce the Boren Amendment's substantive requirement that the state pay rates reasonable and adequate to meet the requirements of the statute. Even if this Court were inclined to reconsider that holding, this case is hardly the appropriate vehicle for such

reconsideration, at least insofar as the present phase of the litigation is concerned. The Fifth Circuit's decision is limited to the issue of procedural compliance with the Boren Amendment (except to the extent that the Fifth Circuit recognized that the district court erred in dismissing both the procedural and substantive challenges contained in the Hospitals' Complaint). Even the dissenting opinion in *Wilder* recognized that health care providers should have the right to enforce procedural compliance with the statute:

> Section 1396a(a)(13)(A) establishes a procedure for establishing such rates of reimbursement. The first step requires the States to make certain findings. The second and only other step requires the States to make certain assurances to the Secretary and the Secretary – not the courts – to review those assurances. Under the logic of our case law, respondent arguably may bring a [Sect.] 1983 action to require that rates be set according to that process.

496 U.S. at 527 (Rehnquist, J., dissenting)

This action is precisely the kind referred to above in the *Wilder* dissent – an action to require that rates be set according to the findings requirement. The Hospitals' separate challenge to substantive rates has not yet been reached, and perhaps will not be reached if they prevail on the issue of procedural compliance. In any event, the case does not present itself in the correct posture for reconsideration of *Wilder*.

Nor is reconsideration of *Wilder* warranted by this Court's intervening decision in *Suter v. Artist M.*, 112 S.Ct. 1360 (1992). As the majority in *Suter* recognized, that

case was distinguishable on its facts from *Wilder*. A comparison of the provisions of the Boren Amendment and the statute at issue in *Suter*, the Adoption Assistance and Child Welfare Act of 1980, is an apples and oranges comparison. This Court found that the former statute contained statutory language evidencing Congressional intent to confer an enforceable right upon health care providers, while the latter statute did not contain similar language in favor of private individuals.

LDHH also takes the convenient position that *Wilder* should be overruled in order to deprive federal courts of any authority whatsoever to enforce the Boren Amendment, ostensibly for the reason that issues pertaining to Medicaid reimbursement are too complicated for the judiciary. Yet this argument is belied by what has actually happened to date in decisions such as *Amisub, Folden, Illinois Health Care Ass'n, Mississippi Hospital Ass'n, Pinnacle* and this case. These decisions have drawn an appropriate balance between the deference rightfully afforded to state regulatory decisions and the need to assure uniform compliance with the minimum requirements of federal law.

For LDHH to argue that "judicial enforcement of the Boren Amendment has enmeshed lower federal courts in the minutiae of Medicaid rate-making activities, an area where they have little if any expertise" is to trivialize the careful analysis and thorough efforts employed by circuit courts across the country as they have sought to uphold the guarantees of the statute while respecting state autonomy to the extent reasonably possible. And for the federal courts to abandon the function of assuring Boren Amendment compliance would be an abandonment of

not only the rights of the health care providers, but ultimately of the rights and needs of health care recipients.

CONCLUSION

The court of appeals' determination that LDHH has failed to comply with the minimum requirements of federal law under the Boren Amendment is not in conflict with any statute, with any prior decisions of this Court nor with the decision of any court of appeals from any circuit. Very simply, this case is about a state agency which sought inappropriately to find a short-cut around the requirements of federal law. The Fifth Circuit appropriately threw up a roadblock, and the case should now proceed in the district court in a manner consistent with the court of appeals' ruling. LDHH's Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

DAVID L. RAMSEY, SECRETARY, DEPARTMENT OF HEALTH AND HOSPITALS, STATE OF LOUISIANA, *et al.*,
Petitioners,

v.

ABBEVILLE GENERAL HOSPITAL, *et al.*,
Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For the Fifth Circuit

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REPLY BRIEF FOR THE PETITIONERS

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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

No. 93-1349

DAVID L. RAMSEY, SECRETARY,
DEPARTMENT OF HEALTH AND HOSPITALS,
STATE OF LOUISIANA, ET AL., PETITIONERS

V.

ABBEVILLE GENERAL HOSPITAL, ET AL.,
RESPONDENTS

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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1. Forty-three States, joined by the District of Columbia and the Territory of Guam, have filed a brief as *amici curiae* supporting petitioners. The *amici* States urge the Court to reconsider its decision in *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), and further state that "if *Wilder* is not overruled, it is urgently important that this Court clarify the standard of judicial review to be applied in Boren Amendment cases . . . [and] provide guidance to the lower courts concerning the content of the procedural 'finding' requirement of the Boren Amendment." States' Br. 12-13.

The States' Brief removes any possible doubt about the importance of the questions presented in this case. Forty-three States believe that judicial application of the Boren Amendment "has gone terribly wrong" and "now poses a serious threat to the States' administration of the Medicaid program." States' Br. 3. The *amici* States offer striking examples of the pathological quality of recent Boren Amendment litigation. *Id.* at 6-9. Because Medicaid is a cooperative federal-state program that accounts for a large percentage of the States' total spending, see *id.* at 2, the States' Brief weighs heavily in favor of granting the petition.

2. Respondents assert (Br. in Opp. 20) that there is no disagreement in the courts of appeals concerning the content of the procedural "findings" requirement of the Boren Amendment or the applicable standard of judicial review. That is not so. The lower court itself recognized (Pet. App. 8a n.7) that its ruling on the standard of review conflicts with the Seventh Circuit's decision in *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460, 1462-63 (1993), which applied an arbitrary and capricious standard of review to evaluate compliance with federal law. See Br. in Opp. 22 (conceding that *Bradley* applied a deferential standard of review). In this case, in contrast, the Fifth Circuit announced that it would conduct "*de novo* review of the state's factfinding process" (even though the text of the statute does not refer to a "factfinding process") and "arbitrary and capricious review of the findings and rates." Pet. App. 11a. The Tenth Circuit has adopted still another approach, reviewing *de novo* "whether the plan is procedurally and substantively in compliance with the requirements of the [Boren Amendment.]" *Amisub (PSL), Inc.* v. *Colorado Department*

of Social Servs., 879 F.2d 789, 795 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990).[1/]

In addition, the lower court's expansive interpretation of the procedural "findings" requirement conflicts with this Court's statements in *Wilder* that the findings requirement is "bare" and "perfunctory." 496 U.S. at 510, 513. Respondents' suggestion (Br. in Opp. 14-17) that the Court did not mean anything by these statements cannot be credited. The majority in *Wilder* concluded that judicial review of the *substantive* adequacy of Medicaid rates is warranted precisely because review of compliance with the "bare" procedural requirements, without more, would render the Boren Amendment "a dead letter." 496 U.S. at 514. If this Court had shared the Fifth Circuit's expansionist vision of the procedural "findings" requirement, that argument would have been nonsensical, because procedural review under the Fifth Circuit's standard involves a wide-ranging, intrusive and *de novo* inquiry into the States' rate-making processes. See Pet. 12-13. If a court, applying a highly demanding *de novo* standard of review, concludes that the State has engaged in an adequate "factfinding process" that has produced sufficient information and analysis to substantiate the conclusion that Medicaid rates are reasonable and adequate, it is hard to imagine how the same court, applying a *deferential* standard

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[1/] Respondents attempt to side-step the disagreement in the courts of appeals by asserting that "*all of the cases, whether describing their review process as 'de novo' or otherwise,*" "ask the question" whether the State possessed "a 'minimum quantum of evidence' to substantiate [the] agency's assurances." Br. in Opp. 22 (emphasis in original). But the courts of appeals are clearly not all "asking the same question," as the plain terms of their discordant opinions make clear. Moreover, it matters a great deal whether the review process is "'*de novo*' or otherwise" where, as here, the court engages in intrusive review of the *quality* of the State's rate-setting process under the guise of determining whether the State has made any findings at all.

of review, could possibly conclude that the rates are substantively inadequate.[2/] Accordingly, the Fifth Circuit's broad interpretation of the "findings" requirement is impossible to reconcile with this Court's decision in *Wilder*.[3/]

3. Respondents repeatedly misstate petitioners' position by attributing to them the view that "a state agency may comply with the findings requirement by merely claiming that it has done so." Br. in Opp. 11-12; see also *id.* at 14-17, Petitioners' position is that the Boren Amendment requires participating States actually to "find" that their rates are reasonable and adequate, and not merely to claim to have done so. It is also petitioners' position that the lower court's expansive definition of the "findings" requirement goes much too far. The issue at this juncture is whether the lower court's approach is incorrect and unreasonable. Respondents do not even attempt to explain how the court's insistence on an extensive "factfinding process" can be derived from the ordinary meaning of the statutory term "find," which is simply "to arrive at (a conclusion)" or to "determine and declare." See Pet. 11 (quoting *Webster's Third New International Dictionary* 852 (1968)).

Respondents suggest that LDHH had essentially no support for its findings as to the adequacy of reimbursement

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[2/] Of course, the rates could well be adequate even if the "factfinding process" did not meet the Fifth Circuit's standard.

[3/] The court of appeals' definition of the scope of the "findings" requirement also conflicts with the Ninth Circuit's decision in *Folden* v. *Washington State Dep't of Social & Health Servs.*, 981 F.2d 1054, 1057 (1992), which recognized that "the finding process does not require any special studies or written findings." In this case, in contrast, the court of appeals held that LDHH "conducted no studies" and did not reduce its analyses to writing. Pet. App. 17a, 21a.

rates. See, *e.g.*, Br. in Opp. 13, 19, 27. The record shows the opposite. The State submitted a lengthy and detailed affidavit from a responsible State official describing the numerous factors the State took into account in evaluating the adequacy of rates. See Appellees' Record Excerpts 31-54 (affidavit of Helene Robinson). The lower courts were required to accept statements in the affidavit as true given the summary judgment posture of the case, and there was no evidence in the record to rebut Robinson's affidavit.

In addition to misstating petitioners' position, respondents erroneously state that "[t]he court of appeals' decision does not dive into the complexities of Medicaid reimbursement methodology or substitute its judgment as to such methodology for that of the state agency." Br. in Opp. 23. In fact, the court of appeals held that "the method by which LDHH promulgated the initial target rates fails the Boren Amendment test." Pet. App. 19a. See also *id.* at 24a (identifying alleged "fallacy in LDHH's rate-setting methodology"). As we have explained, see Pet. 12 n.6, there is in fact no "fallacy." In any event, the lower court, in the guise of determining whether LDHH complied with the simple procedural requirement that it "find" that its rates are adequate, clearly did "dive into the complexities of Medicaid reimbursement methodology" by rejecting Louisiana's basic rate-setting methodology, which has been approved by the federal government and which has been in effect since 1983. In doing so, it once again exceeded the limits that courts respect in reviewing agency action. See *Environmental Action* v. *FERC*, 996 F.2d 401, 407 (D.C. Cir. 1993) (because "[i]ssues of rate design are fairly technical and, insofar as they are not technical, involve policy judgments that lie at the core of the regulatory mission," judicial "review is deferential") (quotation omitted).

Respondents praise the court of appeals because it merely told Louisiana "that it did not do *nearly enough* by way of findings," and that "it must do something more," without specifying what additional actions are required to survive judicial review. Br. in Opp. 18, 19 (emphasis in original). That is no cause for congratulation. Any judicial gloss on the statutory text should provide clear guidance to the States. Instead, the court of appeals has left Louisiana and other States to guess at what might satisfy a court, years after the fact, reviewing one of the State's most important, complex, and expensive programs. Further review is warranted to correct that situation.

4. Respondents assert (Br. in Opp. 6-11) that the petition contains several "perceived misstatements of fact and law." *Id.* at 6. The "misstatements" that respondents identify are not misstatements at all, and, for the most part, are not even relevant to the questions presented for review.

Respondents suggest (Br. in Opp. 9-10) that LDHH did not comply with its own interpretation of the findings requirement — *i.e.*, that LDHH did not actually conclude that its Medicaid rates met the requirements of the Boren Amendment. That suggestion is directly contradicted by the findings of both courts below, which rested on clear supporting evidence. See Pet. App. 32a (LDHH "properly set forth findings for the decision it made in adopting changes in its plan during the years 1985, 1986, 1988, 1989 and 1990"); *id.* at 7a (LDHH "made its findings and submitted assurances to HCFA for approval of its initial Medicaid plan in 1984 *and all subsequent amendments to the plan's reimbursement rates*") (emphasis added).

Respondents also assert (Br. in Opp. 8-9) that HCFA has not approved LDHH's 1988 amendment. That point was entirely irrelevant to the issues decided by the court of

appeals. That court instead criticized the State's basic rate-setting methodology, which had been approved by HCFA in 1983. HCFA's disapproval of the 1988 amendment did not call into question the propriety of the basic methodology, but questioned only whether the amendment had adequate support. HCFA's disapproval is not yet final and is now the subject of administrative review.

Respondents take issue with petitioners' statement that Louisiana's Medicaid Plan provides an incentive for cost control. See Br. in Opp. 6-7. Under Louisiana's Medicaid system, hospitals are fully reimbursed only if the rate at which their costs increase is less than or equal to a "target rate." The unrebutted record evidence was that the target rates were intended to and did provide an incentive for hospitals to contain their costs.

Respondents' assertion (Br. in Opp. 7) that there is no "credible" evidence in the record that LDHH froze Medicaid rates because of the State's depressed economy is incorrect. The responsible LDHH official so testified in a sworn affidavit. See Appellees' Record Excerpts 39-40; 42-26. The affidavit also rebuts respondents' assertion (Br. in Opp. 8) that there is no record support for petitioners' statement that the national cost index was producing target rate increases that were too large for Louisiana. See Appellee's Record Excerpts 42-45. Contrary to respondents' assertion (Br. in Opp. 7), the court of appeals did not reject the affidavit as "largely discredited" by deposition testimony. Instead, the court of appeals accepted the affidavit at face value, as it was required to do given the summary judgment posture of the case, but concluded (erroneously in petitioners' view) that the extensive activity described in the affidavit was legally insufficient to satisfy the findings requirement. See Pet. App. 19a-20a n.15.

5. The States' Brief makes a compelling case for overruling *Wilder*. The vague terms of the Boren Amendment are not susceptible of coherent and consistent judicial enforcement, and *Wilder* has resulted in protracted, inefficient litigation in a field where federal courts have very little, if any, expertise. See States' Br. 9 and n.9. Respondents contend (Br. in Opp. 24-25) that this case is not an appropriate vehicle for reconsidering *Wilder* because the court of appeals considered only petitioners' compliance with the procedural requirements of the statute. In fact, *Wilder* held that *both* the procedural and substantive requirements of the Boren Amendment are enforceable under 42 U.S.C. § 1983, and for this purpose did not distinguish between them. There is no impediment in this case to a decision overruling *Wilder*.[4/]

Moreover, if the Court were to reconsider *Wilder*, it could decide that, in the light of *Suter* v. *Artist M*, 112 S. Ct. 1360 (1992), there should be no Section 1983 actions under the Boren Amendment or that there should be only substantive review, with the burden on the plaintiffs to offer evidence (and none was offered here) that reimbursement rates are inadequate within the meaning of the Amendment. Either disposition would require that the decision below be vacated.

[4/] Nor is it true that the dissenting justices in *Wilder* agreed that the procedural requirements of the Boren Amendment were judicially enforceable; the dissent said only that "respondent *arguably* may bring a 1983 action to require" compliance with the Amendment's procedural requirements. 496 U.S. at 527 (Rehnquist, J., dissenting) (emphasis added).

CONCLUSION

For the foregoing reasons, and those stated in the petition, it is respectfully submitted that the petition for a writ of certiorari should be granted.

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No. 93-1349

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

DAVID L. RAMSEY, SECRETARY, DEPARTMENT OF HEALTH AND HOSPITALS, STATE OF LOUISIANA, *ET AL.*, PETITIONERS

V.

ABBEVILLE GENERAL HOSPITAL, *ET AL.*, RESPONDENTS

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF THE STATES OF INDIANA, ALASKA, ARIZONA, CALIFORNIA, COLORADO, CONNECTICUT, FLORIDA, HAWAII, IDAHO, ILLINOIS, IOWA, KANSAS, KENTUCKY, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, TEXAS, UTAH, VERMONT, VIRGINIA, WEST VIRGINIA, WASHINGTON, WISCONSIN, THE DISTRICT OF COLUMBIA, AND THE TERRITORY OF GUAM, AS AMICI CURIAE SUPPORTING PETITIONERS

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QUESTIONS PRESENTED

1. Whether this Court should reconsider its decision in *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), that the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A), can be enforced by health care providers through an action under 42 U.S.C. § 1983.

2. Whether a court, in reviewing the procedural requirement of the Boren Amendment that the State "find[]" that its Medicaid reimbursement rates are "reasonable and adequate," is authorized to engage in *de novo* review of the quality of the State's "factfinding process," the "quantum of evidence" that supports the State's findings, and the State's rate-setting methodology.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-1349

DAVID L. RAMSEY, SECRETARY,
DEPARTMENT OF HEALTH AND HOSPITALS,
STATE OF LOUISIANA, ET AL., PETITIONERS

V.

ABBEVILLE GENERAL HOSPITAL, ET AL.,
RESPONDENTS

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF OF THE STATES OF INDIANA, ET AL., AS AMICI CURIAE SUPPORTING PETITIONERS

INTEREST OF AMICI CURIAE

The 43 States that join in this amicus brief all participate in the Medicaid program or, in the case of Arizona, a similar program under a special federal grant. Medicaid is a cooperative federal-state program that provides federal

financial assistance to States for reimbursing certain costs of medical assistance for the indigent. The States and the federal government spent a total of $91.5 billion on the Medicaid program in Fiscal Year 1991, far in excess of spending for any other state or federal means-tested benefits program.[1/] The States contributed $39.3 billion, or 43 percent, of that total. *Id.* Total Medicaid spending rose to $118 billion in 1992, and continues to increase.[2/]

The States' contribution to Medicaid has skyrocketed along with overall Medicaid spending. The States' contribution rose from $14.9 billion in FY 1982 to $50.3 billion in FY 1992. Green Book at 1646-47. These enormous expenditures represent a substantial and increasing percentage of total State spending for all purposes. Between 1987 and 1991, Medicaid spending grew from 10 percent to 14 percent of total spending by the States, and, except for spending on elementary and secondary education, is the States' largest budgetary item. *Medicaid Sourcebook* at 491.[3/] In many States, the rate of increase in Medicaid spending now equals or exceeds the entire amount of new funds available from all sources in a given year.

The Boren Amendment was intended to grant States greater flexibility to control Medicaid costs and to reduce

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[1/] Congressional Research Service, 103d Cong., 1st Sess., *Medicaid Source Book: Background Data and Analysis* 468 (Comm. Print 1993) ("*Medicaid Sourcebook*").

[2/] Staff of House Comm. on Ways and Means, 103d Cong., 1st Sess., *1993 Green Book: Overview of Entitlement Programs* 1647 (Comm. Print 1993) ("*Green Book*").

[3/] The statistics include federal grant-in-aid as part of state Medicaid spending, but exclude local funding. See *id.* at 491 n.13.

federal oversight of State reimbursement plans. In *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), this Court held that health care providers may bring actions under 42 U.S.C. § 1983 to enforce the provisions of the Boren Amendment. *Wilder* has resulted in a flood of litigation challenging State compliance with the Boren Amendment.[4/] Boren Amendment litigation has proved to be extremely costly and disruptive, as courts have imposed unrealistic requirements and engaged in micro-management of State Medicaid programs. Indeed, federal courts are now exercising greater oversight than the Department of Health and Human Services exercised before the Boren Amendment was enacted. Obviously, something has gone terribly wrong. Judicial misapplication of the Boren Amendment now poses a serious threat to the States' administration of the Medicaid program, and warrants the intervention of this Court. In our view, the questions presented in this case are at the center of the problem with the Boren Amendment.

The *amici* States believe that this case presents an appropriate opportunity for the Court to reconsider its decision in *Wilder*. At a minimum, the *amici* States urge the Court to grant review for purposes of establishing that the scope of judicial review in Boren Amendment cases is properly limited and that the decisions of responsible State officials concerning Medicaid reimbursement methodologies are accorded significant deference when reviewed by courts.

REASONS FOR GRANTING THE PETITION

The *amici* States will address two reasons for granting the petition for a writ of certiorari. First, the Court's decision in

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[4/] The Appendix to this brief lists 96 Boren Amendment cases, including 41 cases decided since this Court's decision in *Wilder*.

Wilder has proved to be unworkable, and should be reconsidered. Second, there is now a "bedlam" of disagreement in the lower courts on the content of the requirements of the Boren Amendment as well as on the appropriate standard of judicial review, with numerous courts engaging in a highly detailed review of reimbursement systems and failing to give substantial deference to the Medicaid reimbursement decisions made by State officials.

I. THE COURT SHOULD RECONSIDER ITS DECISION IN *WILDER*

The Boren Amendment provides that participating States must "find[], and make assurances satisfactory to the Secretary," that their rates are "reasonable and adequate" to meet the costs that must be incurred by "efficiently and economically operated facilities" to ensure that patients have "reasonable" access to services of "adequate" quality. 42 U.S.C. § 1396a(a)(13)(A). The Secretary has declined to adopt a national definition of any of these open-ended statutory terms, on the ground that "States should determine the factors to be considered in determining what rates are 'reasonable and adequate' to meet the costs of 'efficiently and economically operated facilit[ies].'" *Wilder*, 496 U.S. at 507 (quoting 48 Fed. Reg. 56049 (1983)).

Congress' "primary objective" in enacting the Boren Amendment was "to free States from reimbursement according to Medicare 'reasonable cost' principles." *Wilder*, 496 U.S. at 515. This was expected to lead to a reduction in the skyrocketing growth of Medicaid expenditures. See S. Rep. No. 471, 96th Cong., 1st Sess. 28 (1979). Also, "Congress sought to decentralize the method for determining rates" and to "g[i]ve States leeway in adopting a method of computing rates." *Wilder*, 496 U.S. at 515. Congress intended "that the primary responsibility for developing rates be transferred to

the States." *Id.* at 516 (quoting S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981) ("[T]he committee expects that the Secretary will keep regulatory and other requirements to the minimum necessary to assure proper accountability, and not to overburden the States and facilities with unnecessary and burdensome paperwork requirements").

In *Wilder*, a closely divided Court held that health care providers can bring actions under 42 U.S.C. § 1983 to compel States to comply not only with the "bare" procedural requirement of the Amendment, but also with the substantive requirement that rates must in fact be reasonable and adequate. 496 U.S. at 512-13. The Court declined to specify the appropriate standard of judicial review, but observed: "That the amendment gives the States substantial discretion in choosing among reasonable methods of calculating rates may affect the standard under which a court reviews whether the rates comply with the amendment." *Id.* at 519.

Wilder has produced an avalanche of litigation challenging the States' compliance with the Boren Amendment. Experience in these cases has shown that the courts are unable to fill the "definitional abyss" created by the vague terms of the Boren Amendment. *Lett* v. *Magnant*, 965 F.2d 251, 253 (7th Cir. 1992). The problem is not simply that federal judges have no expertise in determining whether rates are adequate to cover the costs that "must be incurred by efficiently and economically operated" health care providers; even the experts are baffled by the vague generalities of the Boren Amendment. The Health Care Financing Administration (the federal agency that administers Medicaid at the federal level) has recognized that "the measurement of efficiency remains elusive as a result of continued weaknesses in the ability of researchers to account for differences in

hospital outputs' and input prices." 56 Fed. Reg. 26126 (June 6, 1991).[5/]

Unfortunately, due perhaps to the substantial ambiguities in the statute, many lower courts have involved themselves in the details of the State's rate-setting processes, and have imposed elaborate and unwarranted requirements on the States. Judicial review has become intrusive and unpredictable, and has disrupted the States' administration of the Medicaid program. The following examples illustrate the severe problems created by courts attempting to enforce the Boren Amendment.

- In **Alaska**, nursing home payment rates are the highest in the United States, and HCFA repeatedly has expressed concern that the State's rates are in excess of the maximum permitted under federal law. Nursing homes nevertheless brought an action under 42 U.S.C. § 1983, and a state court invalidated the State's "reasonableness cap" on its rates on the ground that state officials had not identified

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[5/] A nationally prominent consultant in the area of Medicaid reimbursement, appearing as an expert on behalf of nursing homes challenging New Jersey's reimbursement system, testified that it is difficult, if not impossible, to identify and determine efficient and economic facilities with precision, and that she was "very reluctant to say exactly where these lines should be drawn because it is a matter of judgment." Testimony of Barbara Manard, Hearing Transcript at 3.75, *New Jersey Ass'n of Health Care Facilities, Inc.* v. *Gibbs*, 838 F. Supp. 881 (D. N.J. 1993); see also Tr. at 1.40, 1.56, 1.65, 2.98, 2.99, 2.116. Nonetheless, courts have invalidated State reimbursement systems when States fail to "identify and determine [ ] efficiently and economically operated [facilities]." See, *e.g.*, *Pinnacle Nursing Home* v. *Axelrod*, 928 F.2d 1306 (2d Cir. 1991); *Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990).

"efficient and economic" providers.[6] On appeal, the Alaska Supreme Court rejected the trial court's interpretation of the Boren Amendment (and in so doing disagreed with the Tenth Circuit's decision in *Amisub (PSL), Inc.* v. *Colorado Department of Social Services*, 879 F.2d 789, 795 (1989), cert. denied, 496 U.S. 935 (1990)), but nevertheless affirmed the trial court's judgment on the ground that the State had not made "concrete findings, based on studies of existing facilities." 856 P.2d at 761-64.

- In **Missouri**, the State adopted a generous reimbursement plan for nursing homes in 1990 under which the vast majority of nursing homes would receive sufficient reimbursement to cover all of their allowable costs. A federal district court found the plan in violation of the procedural requirements of the Boren Amendment because the State had not conducted separate studies showing that each of its standards for allowable costs was a proper measure of provider efficiency.[7]

- **New York's** Medicaid reimbursement system was developed over three years under a grant from HCFA. The system is considered so advanced that the federal government may adopt a similar system for the Medicare Program. Federal and state courts nevertheless have invalidated aspects of the New York system under the Boren Amendment on the ground that the State's findings justifying its rates did not follow the format established by cases in other jurisdictions —

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[6] *Department of Health and Social Servs.* v. *Alaska State Hosp. & Nursing Home Ass'n*, No. 3AN-90-859 Civil (Sup. Ct.), *aff'd*, 856 P.2d 755 (Alaska 1993).

[7] *Missouri Health Care Ass'n* v. *Stangler*, 765 F. Supp. 1413 (W.D. Mo. 1991).

including cases that were decided years after the New York system was in place.[8/]

- **Oklahoma's** reimbursement system for nursing homes was challenged on grounds that the State had not made adequate "findings" that the system complied with the Boren Amendment. No evidence was presented that the rates were inadequate in any respect, yet the State was forced to make new, more detailed "findings." *Oklahoma Nursing Home Ass'n* v. *Demps*, 816 F. Supp. 688 (W.D. Okla. 1992). The State hired an outside consulting firm which was an expert in the field, to assist in developing the court-ordered findings, but the court, with no evidentiary hearing, criticized various details in the report and ordered the State to make additional findings. Order, Sept. 28, 1993. This required further extensive work by the State and the consultant, yet there was never one shred of evidence presented that the rates were actually inadequate.

- In **Oregon**, the court held that the State had not satisfied the Boren Amendment's findings requirement. The court refused to consider whether the State's rates were adequate. Instead, it invalidated the State's Medicaid rates and ordered the State to reimburse providers "in accordance with the prior, validly promulgated and approved plan for the entire time during which the invalid plan was in effect and until a new plan is promulgated." *Volk* v. *Oregon Dep't of Human Resources*, 799 P.2d 658, 664 (Or. App. 1990). Under this approach, a State's failure to comply with a court's latest conception of the findings requirement may result in an order requiring millions of dollars in retroactive payments,

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[8/] *Pinnacle Nursing Home* v. *Axelrod*, 719 F. Supp. 1173 (W.D.N.Y. 1989), *aff'd*, 928 F.2d 1306 (2d Cir. 1991); *In re Avon Nursing Home* v. *Axelrod*, 195 A.D.2d 1046, 601 N.Y.S.2d 725.

even if the State's rates are more than adequate to cover the costs of efficient providers.

- **Washington** adopted a new payment system in 1987 and immediately found itself a defendant in a Boren Amendment suit brought by hospitals, even though a number of hospitals in the State had entered into private contracts with HMOs under which they agreed to accept rates equal to or less than the Medicaid rates that were challenged as "inadequate." The court nevertheless invalidated Washington's system for failure to identify efficiently and economically operated providers. *Multicare Medical Ctr.* v. *Washington*, 768 F. Supp. 1349, 1382-83 (W.D. Wash. 1991).

Even those States that have prevailed in Boren Amendment litigation have generally done so only after lengthy and expensive litigation. See, *e.g.*, *Folden* v. *Washington State Dep't of Social & Health Servs.*, 981 F.2d 1054 (9th Cir. 1992). A typical Boren Amendment case is complex, involves extensive discovery, often results in the State hiring expensive outside consultants, and interferes with the State's efforts to modify and improve its payment system.[2/]

The high costs of Boren Amendment litigation are not justified by any gain to recipients of Medicaid benefits. The Fifth Circuit's decision in this case is one of many that considers only the State's compliance with the asserted

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2/ The complexity of Boren Amendment litigation can be sensed from the length of the opinions in two cases where States prevailed. In *Folden v. Washington State Department of Social & Health Services*, 744 F. Supp. 1057 (W.D. Wash. 1990), the district court's decision spans 27 pages in the Federal Supplement. The opinion in *Gibbs* is 48 pages. See 838 F. Supp. 881.

"procedural" requirements of the Boren Amendment, without any inquiry into the adequacy of the State's reimbursement rates. It is impossible to see what legitimate purpose is served by protracted litigation over the adequacy of a State's "finding" that its reimbursement rates are reasonable, when (as in this case) there is no attempt by the plaintiff providers to prove that the rates are inadequate to cover the costs that must be incurred by an efficient provider. Litigation over these "procedural" issues is expensive and disruptive for the States, and does not further the underlying purpose of the Medicaid program of providing care to the indigent.

For these reasons, as well as the reasons stated in the petition for a writ of certiorari, see Pet. 17-21, the *amici* States join Louisiana in asking this Court to reconsider whether the Boren Amendment can be enforced by health care providers through an action under 42 U.S.C. § 1983.

II. THE COURT OF APPEALS' DECISION ADDS TO THE CONFUSION OVER THE REQUIREMENTS OF THE BOREN AMENDMENT AND THE APPROPRIATE STANDARD OF JUDICIAL REVIEW

If *Wilder* is not overruled, at the very least this Court should clarify that the standard of judicial review in Boren Amendment litigation — an issue expressly left open in *Wilder* — must be highly limited and deferential. The lower courts have frequently engaged in point-by-point review of the reasonableness of the details of a State's findings and reimbursement plan. It is unthinkable that this Court would permit this degree of intrusive review of the internal actions of federal agencies, and interests in comity and federalism demand that the Court put a stop to such review of State agencies, especially in an area where Congress intended them to have substantial flexibility.

The instant case typifies the lower courts' willingness to micro-manage State Medicaid reimbursement systems. The court of appeals considered whether the State had examined cost data from a "scientific" sample of hospitals, and whether the State should have conducted a separate study of labor costs rather than examining only total costs. Pet. App. 21a-22a. Other courts have focused on similar minutiae. See, *e.g.*, *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460, 1466 (7th Cir. 1993) (reviewing the State's estimate of the number of minutes it takes to feed a nursing home patient). Such micro-management by federal courts of Medicaid reimbursement plans defeats a fundamental purpose of the Boren Amendment, which was to reduce federal oversight of state reimbursement plans.

In addition, as the court of appeals acknowledged, there is "bedlam" in the lower courts over the proper standard for reviewing compliance with the Boren Amendment. Pet. App. 9a n.8. See *Department of Health and Social Servs.* v. *Alaska State Hosp. & Nursing Home Ass'n*, 856 P.2d 755, 760 n.5 (Alaska 1993) ("courts have been less than consistent in applying standards of review to Medicaid payment schemes"). The Tenth Circuit reviews *de novo* "whether the plan is procedurally and substantively in compliance with the requirements of the [Boren Amendment]." *Amisub*, 879 F.2d at 795. In contrast, the Seventh Circuit applies an arbitrary and capricious standard of review to evaluate compliance with federal law. *Bradley*, 983 F.2d at 1462-63. The Fifth Circuit departed from both the Seventh and the Tenth Circuits in this case by announcing that it would conduct "*de novo* review of the state's factfinding process and arbitrary and capricious review of the findings and rates." Pet. App. 11a. The Third Circuit takes yet another approach, applying the arbitrary and capricious standard to determine whether rates are "reasonable and adequate," but engaging in "plenary review" of the "reasonable access" and "disproportionate share"

requirements. *West Virginia Univ. Hosps., Inc.* v. *Casey*, 885 F.2d 11, 24 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83 (1991).[10/]

The courts' confusion over the appropriate standard of review is closely linked to uncertainty about the *content* of the procedural and substantive requirements of the Boren Amendment. In this case, the court of appeals disregarded this Court's statement that the Boren Amendment imposes only "bare" procedural requirements, *Wilder*, 496 U.S. at 513, and instead defined the procedural "findings" requirement so broadly that it effectively (and erroneously) engaged in APA-type review of the State's rates under a *de novo* standard of review. The court examined the quality of the State's fact-gathering process and the amount of evidence that the State had gathered to support its findings. The court even went so far as to question Louisiana's basic rate-setting methodology — a methodology that had been approved by HCFA and was implemented seven years prior to the filing of this lawsuit.

In sum, if *Wilder* is not overruled, it is urgently important that this Court clarify the standard of judicial review to be

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[10/] There is "bedlam" on other issues as well. *Compare* Pet. 21a ("findings" requirement might not be satisfied by "ongoing process" of fact-gathering and analysis that is not reduced to writing) *with Folden* v. *Washington State Dep't of Social & Health Servs.*, 981 F.2d 1054, 1057 (9th Cir. 1992) ("states are free to create their own methods of arriving at the required findings and . . . the finding process does not require any special studies or written findings"); and *compare Amisub*, 879 F.2d at 796 ("findings" requirement includes requirement that States "identify and determine . . . efficiently and economically operated hospitals") *with Bradley*, 983 F.2d at 1464 (rejecting notion "that a state must identify a reasonable sample of particular existing nursing homes as paradigms of efficiency") and *Alaska State Hosp. Ass'n*, 856 P.2d at 761 ("*AMISUB* test unnecessarily restricts states' flexibility by requiring a specific approach to determining the reasonableness of rates.")

applied in Boren Amendment cases, and to establish unequivocally that the appropriate standard is limited and highly deferential. The Court should also grant the petition for a writ of certiorari in order to provide guidance to the lower courts concerning the content of the procedural "finding" requirement of the Boren Amendment.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX*

ALABAMA

1. *Alabama Hosp. Ass'n* v. *Beasley*, 702 F.2d 955 (11th Cir. 1983).

ALASKA

*2. *State, Dep't of Health & Social Servs., Medicaid Rate Comm'n* v. *Hope Cottages*, 863 P.2d 246 (Alaska 1993).

*3. *Department of Health & Social Servs.* v. *Alaska State Hosp. & Nursing Home Ass'n*, 856 P.2d 755 (Alaska 1993).

*4. *Health Ass'n of Alaska*, v. *Dep't of Health & Social Servs.*, No. 3AN-90-859 (Alaska Aug. 12, 1991).

CALIFORNIA

*5. *California Ass'n of Health Facilities* v. *California*, No. 5-90-1-1089 (E.D. Cal. Oct. 1, 1990).

6. *California Hosp. Ass'n* v. *Schweiker*, 559 F. Supp. 110 (C.D. Cal. 1982).

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* Asterisk indicates that the opinion was rendered subsequent to this Court's decision in *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498 (1990).

COLORADO

7. *Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 698 F. Supp. 217 (D. Colo. 1988), *rev'd and remanded*, 879 F.2d 789 (10th Cir. 1989).

8. *Colorado Health Care Ass'n* v. *Colorado Dep't of Social Servs.*, 842 F.2d 1158 (10th Cir. 1988).

CONNECTICUT

*9. *Bethphage Lutheran Servs., Inc.* v. *Weicker*, 777 F. Supp. 1093 (D. Conn. 1991), *aff'd*, 965 F.2d 1239 (2d Cir. 1992).

*10. *Connecticut Hosp. Ass'n* v. *O'Neill*, 793 F. Supp. 47 (D. Conn. 1992).

DISTRICT OF COLUMBIA

*11. *Capitol Hill Hosp.* v. *District of Columbia*, 769 F. Supp. 16 (D.D.C. 1991).

IDAHO

*12. *Idaho County Nursing Home* v. *Idaho Dep't of Health & Welfare*, 120 Idaho 933, 821 P.2d 988 (Idaho 1991).

13. *Gem State Homes, Inc.* v. *Idaho Dep't of Health & Welfare*, 113 Idaho 23, 740 P.2d 65 (Idaho App. 1987).

ILLINOIS

*14. *Illinois Council on Long Term Care* v. *Bradley*, 759 F. Supp. 1309, *aff'd*, 957 F.2d 305 (7th Cir. 1992), *cert. denied*, 113 S. Ct. 55 (1992).

*15. *Illinois Health Care Ass'n* v. *Bradley*, 776 F. Supp. 411 (N.D. Ill. 1991), *aff'd*, 983 F.2d 1460 (7th Cir. 1993).

*16. *Illinois Hosp. Ass'n* v. *Edgar*, 765 F. Supp. 1343 (N.D. Ill. 1991).

17. *Illinois Health Care Ass'n* v. *Suter*, 719 F. Supp. 1419 (N.D. Ill. 1989).

18. *Illinois Council on Long Term Care* v. *Miller*, 579 F. Supp. 1140 (N.D. Ill. 1983).

19. *Illinois Hosp. Ass'n* v. *Illinois Dep't of Pub. Aid*, 576 F. Supp. 360 (N.D. Ill. 1983).

20. *Children's Memorial Hosp.* v. *Illinois Dep't of Pub. Aid*, 562 F. Supp. 165 (N.D. Ill. 1983).

21. *Senn Park Nursing Ctr.* v. *Miller*, 118 Ill. App. 3d 504, 455 N.E. 2d 153, *and*, 118 Ill. App. 3d 733, 455 N.E.2d 162 (Ill. App. 1 Dist. 1983).

INDIANA

*22. *Lett* v. *Magnant*, 965 F.2d 251 (7th Cir. 1992).

*23. *Indiana State Board of Pub. Welfare* v. *Tioga Pines Living Ctr.*, 622 N.E.2d 935 (Ind. 1993), *petition for cert. filed*, Jan. 26, 1994.

*24. *Indiana State Board of Pub. Welfare* v. *Tioga Pines Living Ctr.*, 575 N.E.2d 303 (Ind. App. 1991).

25. *Indiana Dep't of Pub. Welfare* v. *Crescent Manor, Inc.*, 416 N.E.2d 470 (Ind. App. 1981).

KANSAS

*26. *Kansas Hosp. Ass'n* v. *Whiteman*, 835 F. Supp. 1556 (D. Kan. 1993).

*27. *Kansas Health Care Ass'n*, v. *Kansas Dep't. of Social & Rehabilitation Servs.*, 822 F. Supp. 687 (D. Kan. 1993).

*28. *Kansas Health Care Ass'n, Inc.* v. *Kansas Dep't. of Social and Rehabilitation Servs.*, 754 F. Supp. 1502 (D. Kan. 1990), *rev'd*, 958 F.2d 1018 (10th Cir. 1992).

LOUISIANA

*29. *Abbeville General Hosp.* v. *Ramsey*, No. 91-356-B (M.D. La. Sept. 22, 1993), *rev'd*, 3 F.3d 797 (5th Cir. 1993), *petition for cert. filed*, Feb. 24, 1994.

30. *St. Tammany Parish Hospital Serv. Dist.* v. *Dep't Health & Human Resources*, 677 F. Supp. 455 (E.D. La. 1988).

MASSACHUSETTS

*31. *Massachusetts Federation of Nursing Homes, Inc.* v. *Massachusetts*, 772 F. Supp. 31 (D. Mass. 1991), *and*, 791 F. Supp. 899 (D. Mass. 1992).

*32. *Quincy City Hosp.* v. *Rate Setting Comm'n*, 406 Mass. 431, 548 N.E.2d 869 (Mass. 1990).

33. *New England Memorial Hosp.* v. *Rate Setting Comm'n*, 394 Mass. 296, 475 N.E.2d 740 (Mass. 1985).

MICHIGAN

*34. *Health Care Ass'n* v. *Department of Social Servs.*, 899 F.2d 14 (6th Cir. 1990).

*35. *LaPeer County Medical Care Facility* v. *Michigan*, 765 F. Supp. 1291 (W.D. Mich. 1991).

36. *Michigan Hosp. Ass'n* v. *Babcock*, 736 F. Supp. 759 (W.D. Mich. Feb. 11, 1990).

37. *Health Care Ass'n* v. *Babcock*, No. K89-50063 CA (W.D. Mich. May 17, 1990).

38. *Michigan Hosp. Ass'n* v. *Department of Social Servs.*, 738 F. Supp. 1080 (W.D. Mich. 1990).

39. *Michigan Hosp. Ass'n* v. *Department of Social Servs.*, 555 F. Supp. 675 (E.D. Mich. 1983).

40. *Coalition of Michigan Nursing Homes, Inc.* v. *Dempsey*, 537 F. Supp. 451 (E.D. Mich. 1982).

MISSISSIPPI

41. *Mississippi Hospital Ass'n* v. *Heckler*, 701 F.2d 511 (5th Cir. 1983).

MISSOURI

*42. *Missouri Health Care Ass'n* v. *Stangler*, 765 F. Supp. 1413 (W.D. Mo. 1991).

43. *AGI-Bluff Manor, Inc.* v. *Reagen*, 713 F. Supp. 1535 (W.D. Mo. 1989).

44. *SSM Healthcare Ctr.* v. *Reagen*, 681 F. Supp. 625 (W.D. Mo. 1988).

45. *AGI-Bloomfield Convalescent Ctr.* v. *Toan*, 679 S.W. 2d 294 (Mo. 1984).

NEBRASKA

*46. *Nebraska Hosp. Ass'n* v. *Department of Social Servs.*, No. CV91-3005 (D. Neb. June 1, 1992).

47. *Nebraska Health Care Ass'n, Inc.* v. *Dunning*, 575 F. Supp. 176, *and*, 578 F. Supp. (D. Neb. 1983), *aff'd*, 543 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987).

NEVADA

*48. *Hillhaven, Inc.* v. *Nevada, Dep't of Human Resources*, No. CV88-6222 (Nev. Dec. 15, 1992).

NEW HAMPSHIRE

49. *Hoodkroft Convalescent Ctr.* v. *New Hampshire Dep't of Human Servs.*, 701 F. Supp. 17 (D. N.H. 1988), *aff'd*, 879 F.2d 968 (1st Cir. 1989).

NEW JERSEY

*50. *New Jersey Ass'n of Health Care Facilities, Inc.* v. *Gibbs*, 838 F. Supp. 881 (D.N.J. 1993).

NEW YORK

51. *Oberlander* v. *Perales*, 740 F.2d 116 (2d Cir. 1984).

*52. *United Cerebral Palsy Ass'ns.* v. *Cuomo*, 783 F. Supp. 43 (N.D.N.Y. 1991), *aff'd*, 966 F.2d 743 (2d Cir.), *cert. denied*, 113 S. Ct. 599 (1992).

*53. *Rye Psychiatric Hospital Center, Inc.* v. *Surles*, 777 F. Supp. 1142 (S.D.N.Y. 1991).

*54. *Pinnacle Nursing Home* v. *Axelrod*, 719 F. Supp. 1173 (W.D.N.Y. 1989), *aff'd in part & rev'd in part*, 928 F.2d 1306 (2d Cir. 1991).

55. *Friedman* v. *Perales*, 668 F. Supp. 216 (S.D.N.Y. 1987), *aff'd*, 841 F.2d 47 (2d Cir. 1988).

56. *New York City Health & Hosp. Corp.* v. *Heckler*, 593 F. Supp. 226 (S.D.N.Y. 1984).

*57. *Lakeshore Nursing Home* v. *Axelrod*, 181 A.D.2d 333, 586 N.Y.S.2d 433 (A.D. 3d Dep't 1992).

*58. *Rye Psychiatric Hospital Ctr.* v. *State of New York*, 576 N.Y.S.2d 449 (1991), *appeal denied*, 587 N.Y.S.2d 287, (A.D.3d Dep't 1992).

OHIO

*59. *Ohio Hosp. Ass'n* v. *Ohio Dep't of Human Servs.*, 62 Ohio St. 3d 97, 579 N.E.2d 695 (Ohio 1991).

60. *Ohio Academy of Nursing Homes, Inc.* v. *Barry*, 56 Ohio St. 3d 120, 564 N.E.2d 686 (Ohio 1990).

OKLAHOMA

*61. *Oklahoma Nursing Home Ass'n* v. *Demps*, 792 F. Supp. 721 (W.D. Okla. 1992).

62. *Oklahoma Hosp. Ass'n* v. *Oklahoma Dep't of Human Servs.*, No. Civ 83-1274-BT (W.D. Okla. Aug. 24, 1983).

OREGON

*63. *Oregon Ass'n of Homes for the Aging, Inc.* v. *Oregon*, 5 F.3d 1239 (9th Cir. 1993).

64. *Francisco* v. *Department of Human Resources*, No. CV 89-6244-HO (D. Or. July 10, 1990).

*65. *Oregon Ass'n of Hosps.* v. *Dep't of Human Resources*, No. CV 88-225-DA (D. Or. Sept. 25, 1990).

66. *Volk* v. *State*, 104 Or. App. 27, 799 P.2d 658 (Or. App. 1990).

PENNSYLVANIA

*67. *Erie County Geriatric Ctr.* v. *Sullivan*, 952 F.2d 71 (3d Cir. 1991).

68. *Wilmac Corp.* v. *Bowen*, 811 F.2d 809 (3d Cir. 1987).

*69. *Temple Univ.* v. *White*, 729 F. Supp. 1093, *and*, 732 F. Supp. 1327, 732 F. Supp. 1329 (E.D. Pa. 1990), *aff'd*, 941 F.2d 201 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 873 (1992).

70. *Wilmac Corp.* v. *Heckler*, 633 F. Supp. 1000 (E.D. Pa. 1986).

71. *West Virginia Univ. Hosps., Inc.* v. *Casey*, 701 F. Supp. 496 (M.D. Pa. 1988), *aff'd in part & rev'd in part*, 885 F.2d 11 (3d Cir. 1989).

72. *Troutman* v. *Cohen*, 588 F. Supp. 590 (E.D. Pa.), *aff'd*, 755 F.2d 920, *and*, 755 F.2d 924 (3d Cir. 1984).

73. *Children's Hosp. of Philadelphia* v. *Secretary of Dep't of Pub. Welfare*, 568 F. Supp. 1001 (E.D. Pa. 1983).

74. *Citizens General Hosp.* v. *Commonwealth, Dep't of Pub. Welfare*, 125 Pa. Commw. 358, 558 A.2d 125 (Pa. Cmwlth 1989).

75. *Presbyterian-University of Pennsylvania Med. Ctr.* v. *Pennsylvania, Dep't of Pub. Welfare*, 553 A.2d 1027 (Pa. Cmwlth 1989).

76. *Citizens General Hosp.* v. *Pennsylvania Dep't of Pub. Welfare*, 558 A.2d 125 (Pa. Cmwlth 1989).

77. *Grandview Health Homes, Inc.* v. *Pennsylvania Dep't of Pub. Welfare*, 552 A.2d 720 (Pa. Cmwlth 1988).

78. *In re St. Joseph's Hosp.*, 103 Bankr. 643 (Bankr. E.D. Pa. 1989).

TEXAS

79. *Texas Hospital Ass'n* v. *National Heritage Ins. Co.*, 802 F. Supp. 1507 (W.D. Tex. 1992).

80. *Thomas* v. *Johnston*, 557 F. Supp. 879 (W.D. Tex. 1983).

SOUTH CAROLINA

81. *Charleston Memorial Hosp.* v. *Conrad*, 693 F.2d 324 (4th Cir. 1982).

82. *ANCO, Inc.* v. *State Health & Human Servs. Finance Comm'n*, 300 S.C. 432, 388 S.E.2d 780 (S.C. 1989).

UTAH

83. *Weber Memorial Care Ctr.* v. *Utah Dep't of Health*, 751 P.2d 831 (Utah 1988).

VERMONT

84. *Berlin Convalescent Center* v. *Stoneman*, 159 Vt. 53, 615 A.2d 141 (Vt. 1992).

VIRGINIA

85. *Virginia Hosp. Ass'n* v. *Baliles*, 868 F.2d 653 (4th Cir. 1989), *aff'd sub. nom.*, *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498 (1990).

86. *Virginia Hosp. Ass'n* v. *Baliles*, 830 F.2d 653 (4th Cir. 1987).

87. *Vantage Healthcare* v. *Virginia Bd. of Medical Assistance Servs.*, 684 F. Supp. 1329 (E.D. Va.1988).

88. *Mary Washington Hosp., Inc.* v. *Fisher*, 635 F. Supp. 891 (E.D. Va. 1985).

WASHINGTON

*89. *Multicare Medical Ctr.* v. *Washington*, 768 F. Supp. 1349 (W.D. Wash. 1991).

*90. *Folden* v. *Washington State Dep't of Social & Health Servs.*, 744 F. Supp. 1507 (W.D. Wash. April 5, 1990) *aff'd* 981 F.2d 1054 (9th Cir. 1992).

91. *Washington State Hosp. Ass'n* v. *Washington*, No. C86-463D (W.D. Wash. May 19, 1987).

WEST VIRGINIA

92. *United Hosp. Ctr.* v. *Richardson*, 757 F.2d 1445 (4th Cir. 1985).

WISCONSIN

93. *Wisconsin Hosp. Ass'r* v. *Reivitz*, 733 F.2d 1226 (7th Cir. 1984).

94. *Hillhaven Corp.* v. *Wisconsin Dep't of Health & Social Services*, 733 F.2d 1224 (7th Cir. 1984).

95. *St. Michael Hosp. of Franciscan Sisters, Inc.* v. *Thompson*, 725 F. Supp. 1038 (W.D. Wis. 1989).

96. *Wisconsin Hosp. Ass'n* v. *Reivitz*, 630 F. Supp. 1015 (E.D. Wis. 1986), *aff'd in part & vacated in part*, 820 F.2d 863 (7th Cir. 1987).